

PSYCHD

**Discursive power games in therapeutic accounts of Antisocial Personality Disorder
A Foucauldian Discourse Analysis**

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**Discursive power games in therapeutic accounts of
Antisocial Personality Disorder: A Foucauldian
Discourse Analysis.**

by

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**A thesis submitted in partial fulfilment of the requirements for the
degree of PsychD in Counselling Psychology**

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ABSTRACT

Antisocial Personality Disorder (ASPD) is understood as a difficult category to work with in various contemporary mental health settings. Additionally, to date, there is a dearth of research on this topic in Counselling Psychology. Therefore, the aim of this study is to explore how Counselling Psychologists (CoPs) and other Psychological Practitioners (PPs) discursively construct ASPD and to investigate any discursive power games that may be implicated in therapeutic practice accounts. Ten semi-structured interviews were conducted and a Foucauldian Discourse Analysis (FDA) was applied to the data. The findings of the analysis produced five distinct therapeutic subject-positions: “Dangerous to Know”, “Damaged Goods”, “The White Collar Psychopath”, “Resisting to Psychiatric Norms” and “Critical Questioning”. Overall this analysis argues that ASPD is a problematic construct as it is produced by these participants as multiple, power laden and opaque. Additionally, these therapeutic subject-positions highlight how ASPD is variously produced in specific therapeutic contexts, such as medium secure units and private practice/ corporate environments. Such findings may contribute to raising awareness among CoPs and other PPs by making visible the power relations and contextual influences implicated in particular ASPD therapeutic accounts. Finally, it is also proposed that this Foucauldian gaze may be applied in other practice areas, to enable critical thinking in relation to potential uses of psychological knowledge, practice and research.

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Transcription conventions

- [...] indicates where material is deliberately omitted.
- (text) brackets surround words for speech clarification.
- (*text*) brackets with italicized words indicate where, for example, there is laughter.
- [text] indicates a clarification of relevant information.
- (.) indicates a short pause.

(Malson, 1998: 15)

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CHAPTER ONE

The problem of ASPD in Counselling Psychology: An Introduction

1.1 Introduction to Chapter One

This study is about developing a critical discursive space for Counselling Psychologists (CoPs) and other Psychological Practitioners (PPs) in relation to constructions of ASPD in therapeutic work. It is also about the knowledge-power nexus and ASPD as a discursive site as relevant to Counselling Psychology. Such a discursive approach focuses on language as discourse with a particular interest in illuminating any power dynamics implicated in therapeutic talk in relation to ASPD. Thus, inheriting a discursive qualitative approach this study will attempt to address the main research question: *“How do PPs construct ASPD and what are the discursive power relations, if any, in PPs’ therapeutic accounts regarding ASPD?”*.

In order to answer the above research question, a Poststructuralist epistemology influenced by Foucauldian ideas (Foucault, 1961; 1972; 1977; 1982; 1988) will be employed to interrogate and critique the participants ASPD ‘truth claims’. Epistemologically, this study assumes that the construct of ASPD cannot be known empirically, but rather it is understood as a socially constructed object of knowledge (Gergen, 2001; Burr, 2003). This perspective also argues for a critical and reflexive approach in relation to the wider ASPD discourses, ‘truth claims’ and therapeutic practices, as well as for the interrogation of any possible discursive power relations operating within therapeutic accounts.

To realise the objectives of this research inquiry, ten UK professionally trained, accredited and practicing CoPs and other PPs with self-identified ASPD clinical experience were interviewed. The participants were asked to share their knowledge, understanding and experience of ASPD and their therapeutic practice with such clients. The interview transcripts were analysed using FDA. The main focus of the analytic inquiry was to critically explore and contest the participants professional talk, to investigate the discursive constructions of ASPD, to consider how PPs positioned themselves or were positioned in their therapeutic accounts of ASPD and to identify any power relations implicated.

In this Chapter, I will firstly problematise ASPD and provide a rationale for this study. Secondly, I will contextualise this study within the Counselling Psychology domain and briefly refer to the Poststructuralist epistemology that embeds this thesis. Thirdly, I will introduce some central analytic Foucauldian ideas that are relevant throughout this study. Finally, I will offer an overview of the study aims and the possible contribution of this research to Counselling Psychology and the wider profession.

1.2 The problem of ASPD and the rationale for this study

The aim of this section is to problematise the therapeutic construction of ASPD and provide sufficient justification for the rationale of this study. Following this, I argue that ASPD can be understood as a discursively constructed object that is difficult to be defined and known empirically. As an object of discourse ASPD carries social meaning that is changeable historically and culturally. I further suggest, that the analytic approach taken by this study will enable the exploration of linguistic limitations of the

diverse ASDP expert knowledges and highlight any possible power relations implicated in professional talk about ASPD.

To begin with, I propose that ASPD is a complex phenomenon, hard to define as it has been valorised in variable and mutable ways through history. The term ASPD, as an official diagnostic category in the DSM is relatively new. It was firstly introduced in the DSM-2 (APA, 1968) and its linguistic development through time reveals the complex historical conceptual changes ASPD has undergone. Linguistic terms such as 'moral defect', 'psychopathic inferiority', 'psychopathic personality', 'criminal personality', 'psychopathy' and 'sociopathy' have been historically attached to what now is referred to as ASPD (Mish, 1996; Thomas, 1997; First & Tasman, 2004). It has been suggested that the definition of antisocial behaviour against (anti) the societal norms (social) (Mish, 1996; Thomas, 1997) is inconsistent, changeable and value-laden (Cooke, 1998) and I would also argue discursively power-laden. For example, by defining ASPD in relation to societal standards, changes in the law would redefine the conceptualisation of ASPD and consequently the ways in which individuals labelled as ASDP are treated, managed and regulated by legal authorities and the mental health system.

Although considerable attention and effort has been invested in defining and grasping the nature of ASPD by numerous disciplines, such as criminology, psychiatry, psychology, sociology, philosophy, ASPD still remains "somewhat of an enigma in etiological and descriptive terms" (Andrade, 2008: 329). Perhaps this great difficulty emerges even before definition, as there seems to be a great confusion at the very basic level of terminology (Jones, 2012). Whilst *Antisocial Personality Disorder*, *Dissocial Personality Disorder*, *Psychopathic Personality*, *Psychopathy* and *Sociopathy* seem to be used interchangeably in the literature (Andrade, 2008), a

number of researchers have made distinctions between ASPD and psychopathy and have argued that psychopathy is a distinct disorder that overlaps with, but it is distinguishable from ASPD (Hare, 1996; Hare et al, 1996; Patrick, 2005; Semple, 2005; Skeem et al, 2011). Perhaps, this terminological confusion is a testament to the opacity and mutability of the ASPD phenomenon, and thereby its problematic 'nature' within contemporary psychological and therapeutic knowledge and practice.

Despite the diverse perspectives of ASPD, the medical/psychiatric domain has been and continues to be highly influential on shaping contemporary knowledges and practices related to ASPD (Ascoli et al, 2011). It is within this domain that ASPD has been mainly conceptualised, described and categorised. In this context, the Diagnostic and Statistical Manual for Mental Disorders (DSM) (APA, 2013) constitutes the primary diagnostic tool, which is used widely in mental health services where many Counselling Psychologists practice. Whilst DSM, the 'psychiatric bible' (Kutchins & Kirk, 1993), comprises an official 'lingua franca' (Wylie, 1995) for clinicians across the world and offers a formal system for categorising and naming psychological difficulties (Marecek & Hare-Hustin, 2009), it produces truth claims about normality and abnormality and as many have argued pathologises human experience and human suffering (Caplan, 1995; Cooper, 2005; Davies, 2013; Frances, 2013). Thus, the DSM and the diagnostic processes in mental health contexts are mainly informed by a modernist positivistic epistemology that challenges the very humanistic values that embed the profession of Counselling Psychology.

Furthermore, leading mental health organisations and professional bodies that are directly linked to Counselling Psychology through the standardisation of psychological practices and treatment seem to espouse the positivistic ideas under which the psychiatric model thrives. This is evident in how ASPD is defined and

described in official published documents. In the latest edition of the DSM-5 (APA, 2013), ASPD is defined as,

a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy*, *sociopathy*, or *dissocial personality disorder*' (p. 659)¹.

Furthermore, the World Health Organisation (WHO) (1994) International Statistical Classification of Diseases and Related Health Problems (ICD) tenth edition (ICD-10) states that

Dissocial (Antisocial) Personality Disorder, usually coming to attention because of a gross disparity between behaviour and the prevailing social norms²

Similarly, to the DSM-5 and ICD-10 definitions of ASPD, the official website of the NHS states,

Antisocial personality disorder is a particularly challenging type of personality disorder, characterised by impulsive irresponsible and often criminal behaviour. Someone with antisocial personality disorder will typically be manipulative, deceitful and reckless, and won't care for the people's feelings (retrieved September 2016)

whilst the National Institute for Health and Care Excellence (NICE) (2009) guidelines suggests that,

People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated

¹ See Appendix 1: Table 1, DSM-V Diagnostic Criteria for ASPD.

² See Appendix 2: Table 2, ICD-10 Diagnostic Criteria for Dissocial Personality Disorder.

behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feeling of others (p. 4).

The above official definitions and descriptions of ASPD seem to be resourced by the wider dominant psychiatric discourse and thus form a particular disciplinary regime (Foucault, 1980) by determining ASPD in relation to standards of normality and abnormality. These definitions seem to reduce ASPD to binary categorical understandings, such as normal/abnormal, sane/insane, good/bad, and fail to address the complexity of this construct. These contemporary understandings and definitions of ASPD stem back to the early 19th century where the emergence of *moral insanity* signified the conceptual broadening of mental health *illness* to include notions of dangerousness. The historic constructions of ASPD category will be discussed in detail in Chapter Two.

In addition to the dominant medical/psychiatric knowledges, there is a diversity of theoretical perspectives available within the current psychological literature and research in relation to ASPD that provide variable discursive resources for Counselling Psychologists to draw upon. Within this diversity, psychodynamic perspectives (Freud, 1917/1957; Bowlby, 1969; Kernberg & Caligor, 2005) cognitive-behavioural models (Shapiro, 1965; Beck & Freeman, 1990), humanistic approaches (McCulloch, 2012) and social-constructionist theories (Parker, 1999) offer different constructions of ASPD which result in different therapeutic applications³. For example, some classical psychodynamic perspectives view ASPD as a result of an undeveloped superego

³ These expert knowledges will be explored in detail in Chapter Two.

(Freud, 1946) and a domination by the infantile id and its pleasure principles (Friedlander, 1945), whilst from a cognitive-behavioural perspective, ASPD is described in terms of cognitive styles characterised by deviant, egocentric and impulsive mental templates (Beck & Freeman, 1990).

The various theoretical conceptualisations of ASPD, as demonstrated above, illustrate the opacity and mutability of this phenomenon as well as the multiple conceptual and discursive contradictions within contemporary psychological knowledges. Thus, this thesis proposes that a poststructuralist discursive approach will enable the interrogation of the linguistic ambiguities of ASPD constructions and any possible discursive power relations in terms of what it made visible or constrained for the Counselling Psychology and the wider therapeutic profession.

1.3 ASPD and Counselling Psychology

In this section, it is proposed that the problematic nature of ASPD as a psychological construct needs to be considered in relation to the Counselling Psychology profession. Counselling Psychology is a relatively new field in the wider psychological and psychotherapeutic professional domain. It was firstly constituted as a separate section of the British Psychological Society (BPS) in 1982 (Woolfe et al, 2010). Whilst Counselling Psychology has been criticised by many for its vagueness, Woolfe et al (2010) propose that Counselling Psychology is,

a broad church, committed to exploring a range of approaches to inquiry and recognising the contribution of differing traditions in psychology (p. 4).

Furthermore, in the Professional Practice Guidelines for the Division of Counselling Psychology it is stipulated that,

Counselling Psychology has developed as a branch of professional and psychological practice strongly influenced by human science research as well as the principal psychotherapeutic traditions (BPS, 2005: 1).

These guidelines suggest that Counselling Psychology draws both from phenomenological models of practice as well as the traditional scientific psychology, with research aiming to 'marry' the scientific demand for empirical enquiry with the firm values grounded in the primacy of the counselling relationship (BPS, 2005). Hence, Counselling Psychology is situated within competing paradigms (Blair, 2010). On the one hand, working within medical and scientific settings means that Counselling Psychologists have to grapple with positivistic and empirical ideas. On the other hand, Counselling Psychologists are expected to value subjectivity and intersubjectivity, meaning making, the therapeutic relationship, pluralism and anti-discriminatory practice (BPS, 2005). This epistemological tension is highlighted in the term 'scientist-practitioner' (Woolfe et al, 2010), which is often used in reference to Counselling Psychologists (Blair, 2010) and encapsulates the central challenge of negotiating opposing ideologies in the practice of the profession.

One main area where this epistemological tension becomes central is working with diagnosis. This tension is also a central concern for this thesis, since one of the main analytic considerations is how practitioners understand the diagnostic construct of ASPD and how they practice therapeutically with it. The medical/psychiatric model adopts a positivistic approach to diagnosis in mental health by evidencing symptoms of mental disorders using the DSM. However, this approach comes to conflict with

Counselling Psychology as it challenges its grounding principles and values of by taking a non-holistic view of the client and reducing human experience to a cluster of symptoms. Therefore, Counselling Psychologists who find themselves working with the diagnosis of ASPD, are unavoidably located in the heart of these competing ideologies.

Indeed, Counselling Psychologists are expected to navigate through competing epistemologies and practice pluralistically or integratively upholding humanistic values whilst engaging with evidence-based practice (Larsson et al, 2012). Rizq (2007) notes that the ethical premise of Counselling Psychology is invested in challenging modernist assumptions about human experience - both within medical and humanistic perspectives and in valuing post-modern ideas such as pluralism. Pluralism subscribes to the idea that knowledge is relevant and that there are many versions of reality and multiple truths out there (Cooper & McLeod, 2012). Hence, by embracing a pluralistic approach to knowledge and truth, Counselling Psychology calls for the consideration of contradictory epistemologies.

Following this premise, a poststructuralist approach to this research, that maintains a non-essentialist approach to knowledge and truth, has been chosen, in order to critically investigate ASPD as an object of discourse as well as the potential power-laden positioning of practitioners who work therapeutically with such a diagnostic category. The poststructuralist epistemology that embeds this study will be discussed in more detail in Chapter Three, which considers the research method and methodology.

1.4 Language and the Foucauldian gaze

The philosophical work of Michael Foucault (1926-1984) on discourse, power, knowledge and subjectivity has been highly influential and useful to Psychology (Arribas-Ayllon & Walkerdine, 2008) and his contribution is of particular interest to this study. Foucault used archaeological (1961) and later genealogical (1977b) methods to highlight the discursive formations and events that produced knowledge in different historical periods and to uncover the relationship between truth, knowledge and power (Schirato et al, 2012). He analysed the social construction of *madness* (Foucault, 1961), *discipline* (Foucault, 1977), and *sexuality* (Foucault 1978; 1984; 1986) and became best known for his ideas concerning the discursive power and subjectivity (Foucault, 1982).

More specifically, his ideas about *madness* and *badness* (Foucault, 1961; 1977), in relation to psychiatric expert knowledge, are of great relevance to this study. Foucault saw madness as located in a specific cultural space shaped by the wider societal discourse. He exposed the monopoly of the psychiatric regime in defining normality and abnormality (Foucault, 1961) and its legitimisation in regulating individuals who were deemed as *mad*. Foucault (1977) also explored the historic links of madness, criminality and evil as well as the constitution of institutions, such as asylums and prisons, and proposed that *madness* became a discourse of fear.

Furthermore, one of the most important of Foucault's contributions, which is of paramount importance for this study, was his ideas concerning how subjects produce themselves or are produced discursively and take up certain speaking positions which may express distinct power relations and forms of knowledge (Luke, 1999; Schirato et al, 2012). Following this, I discuss Foucault's central ideas on the role of language and

its constitution of knowledge. More particularly, I will present his ideas on discourse, power-knowledge nexus, forms of resistance and subjectivity.

1.4.1 Foucauldian concept of discourse.

Discourse has been widely defined as “a group of ideas or patterned ways of thinking which can be identified in textual and verbal communications, and can also be located in wider social structures” (Lupton, 1992: 145). From a Foucauldian perspective, discourse is understood as a set of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak (Parker, 1994; Lessa, 2006). Discourses do not just describe ‘objects,’ but rather they “systematically form the objects of which they speak” (Foucault, 1978:100) enabling or constraining certain understandings and knowledges and dictating what can be said, by whom, when and where (Weedon, 1987; Parker, 1992).

Discourses become available through language and play a powerful role in shaping subjective experience. Hence, language becomes a medium by which we come to understand ourselves and the world around us. For example, discourses that are legitimised as ‘expert’, such as the ‘psychiatric’ or ‘psychological’ discourse, seem to be authorised in defining what is normal or abnormal, healthy or pathological. A mere example of that is homosexuality, which was included as a mental health disorder in DSM-1 (APA, 1952) and was later removed from DSM-2 (APA, 1968) in 1973 (Drescher, 2015) in accordance with the American Psychiatric Association referendum outcome. Drapetomania (which was used to describe slaves’ uncontrollable urge to escape) and kleptomania (which explains the compulsive shoplifting and originated with the invention of large department stores) (Marecek &

Hare-Mustin, 2009) are two further examples of how the expert DSM discourse pathologised the individual whilst the role of social processes in the development of human distress remained unacknowledged.

Expert discourses, such as those mentioned above, privilege certain aspects of reality whilst simultaneously obscure others. From a poststructuralist epistemological perspective, 'objects', such as ASPD, do not wait to be 'discovered', rather they are constituted by complex power relations and socially produced discourses. This is highly relevant to this thesis which aims to interrogate the discourses related to ASPD and explore what is made visible or excluded in ASPD therapeutic accounts. Thus, ASPD will be analysed as a discursively constructed object that carries social meaning, specific to the context Counselling Psychology.

While in most contemporary mental health contexts, ASDP is considered as a 'real', objective category of disorder, in this analysis, it is suggested that this 'disorder' is constructed. From this perspective, personality disorders are products of historical, social and cultural perceptions and meanings (Marecek & Hare-Mustin, 2009; Sloan, 2009; Ascoli et al, 2011). Therefore, concepts of personality always reflect a historical form of individuality (Seve, 1978) associated with a particular order (Sloan, 2009). Mainstream psychological understandings of ASDP pathologise personality in association with what is widely perceived to be socially acceptable or unacceptable. Additionally, these understandings of ASPD privilege individualistic perspectives and leave social justice issues, such social inequality, unchallenged (Sloan, 2009). Thus, this thesis suggests that it is of critical importance for Counselling Psychologists, and other psychological practitioners, to become aware of the ways they are discursively constructing ASDP as well as any possible implications (if any) this may have for their therapeutic work with such clients.

1.4.2 *The power/knowledge nexus and forms of resistance.*

The notion of power (also termed as *biopower*) is the most important conception in Foucault's work as it forms the analytic basis of discourse (Powers, 2007). Formulating and studying the question of power relations (MacLeod & Durrheim, 2002) in terms of "power at its extremities...where it becomes capillary" (Foucault, 1980: 96) has been central to the Foucauldian project, which aimed to investigate the practices of power "where it installs itself and produces real effects" (Foucault, 1980: 97). Foucauldian power is not understood as "singular, unidirectional, reified phenomenon" but as a "network of interacting forces that are goal-driven, relational and self-organised" (Powers, 2007: 28). This kind of power,

is not exercised from the exterior; it is not *possessed* by an individual, class or group, nor is it *centralised* in the law, economy or state. Rather it is immanent to everyday relationships including economic exchanges, knowledge relationships, sexual relations, etc. (MacLeod & Durrheim, 2002: 43).

Hence, power is not something that is held by a group of people or another but "it incites, it induces, it seduces [and] passes through the hands of the mastered no less than through the hands of the masters" (Deleuze, 1988: 71).

Foucault's concept of power shifted between his early work on institutions (Foucault, 1961; 1963; 1977) and his later work on sexuality and governmentality (Foucault, 1978; 1984; 1986). In the early stages of his work Foucault proposed a judicial model of power and he explored how the creation of modernist disciplines and their principles of order and control 'disindividualise' power. Bentham's Panopticon, which was a central architectural feature in the prisons at the time, became Foucault's

model for describing this regulatory function of power in different institutions. The Panopticon, Foucault (1977) writes,

...is an important mechanism, for it automatises and disindividualises power. Power has its principle not so much in a person as a central in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement whose internal mechanisms produce the relation in which individuals are caught up (p. 202).

Indeed, Bentham's aim was to create an architectural structure that could function on its own regardless of who was operating it; "any individual can operate the machine: in the absence of the director, his family, his friends, his visitors, even his servants" (Foucault, 1977: 202).

A central concept in the Foucauldian view of power is that of resistance, which is understood as inherent and integral property of power relations (Schirato et al, 2012). As Foucault (1978) wrote,

where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power (p. 95).

In his early model of juridical and strategic power, resistance as a practice was seen as subjugated to the employment of power relations. This kind of resistance to such dominating power was entitled as 'tactical reversal' (Thompson, 2003) and individuals who mobilised such resistance were perceived as defiant and caught up within domineering power games. Here, Foucault argued that resistance "is always reactive and, as such, restrictive" (Thompson, 2003: 120), engaging in a direct struggle

with hegemonic forces leaving two options available: either comply or reject this force (Thompson, 2003).

Later in his work, the Foucauldian project turned its focus on understanding the ethic and confessional self and more specifically the particular mechanisms or techniques, which individuals use to manage, shape and regulate their own bodies and thoughts (Schirato et al, 2012). Foucault (1982; 1984) called this concept of power 'governmental power'. In this model, power "operates not by force, but by knowledges that are to be implemented by the self, on the self...to produce truth of the self" (as quoted in Frank, 1998: 335). A new element on this understating is freedom (Thompson, 2003). He writes, "power is exercised only over free subjects, and only insofar as they are free" (Foucault, 1982: 221). This model of power suggests that people construct themselves through the socially available discourses, for example psychological discourses (Parker, 1999) and hence they conform with prevalent norms and eventually become self-regulated subjects.

In this governmental model of power, Foucault (1988) developed a more nuanced form of resistance, which he called 'technologies of the self'. Here, Foucault (1988) was concerned with how people become ethical subjects through their own means and how subjects came to conduct themselves without getting caught up in a state of domination (Schirato et al, 2012). The practice of critique was seen as central to this process of 'self-formation', of 'becoming' a subject. Hence, in this model resistance is not solely concerned with the subjugation of antinomic forces and structures. Rather, resistance as a form of critique, forges new forms of life and existence and cultivates new types of agency that enable us to govern ourselves (Thompson, 2003). Indeed, "the work of critique...is self-formation" (Thompson,

2003:123), and through this practice individuals are seen to expand new ways of thinking and being (Sharpe, 2005).

These Foucauldian models of power and forms of resistance are central to this thesis and will be employed to make visible any possible power games that may operate in the participants' therapeutic accounts of ASPD. Additionally, issues of power are highly important in Counselling Psychology. This is evident in the HCPC (2015) standards of proficiency, which require all practitioner psychologists to

Understand the power imbalance between practitioners and clients and how this can be managed appropriately (p. 7).

Be able to recognise appropriate boundaries and understand the dynamics of power relationships (p.7).

I propose that engaging with critical examination of possible power relations in therapeutic talk is of paramount importance for Counselling Psychologists and other Psychological Practitioners. Sawicki (1991) cautions us that no discourse is inherently liberating or oppressive and that “behoves us as practitioners not to blindly follow (or merely seek to refine) practice prescriptions, but rather to scrutinise the institutional and disciplinary knowledges by which we are positioned” (Kaye, 1999: 35). Thus, espousing the Foucauldian project, this study calls practitioners to consider the wider ASPD ‘truths’ as well as how they produce and regulate themselves in relation to those ‘truth claims’.

1.4.3 Foucault and Subjectivity.

The last Foucauldian idea that is of analytic concern for this study is subjectivity and more specifically the ways in which various ASPD constructions make available certain subject-positions. From a Foucauldian perspective, people in general become subjected to socially constructed ‘objects’ of knowledge (Foucault, 1982) through discourse. Thus, it is possible the ways in which ASPD is constructed may influence how therapists think and practice with such clients, and thereby their subjective experience.

More particularly, the Foucauldian subject is understood as being “subject to someone else by control or dependence, and subject to his own identity by conscience and self-knowledge” (Foucault, 1982: 781). In Foucault’s view, subject-positions are “positions from which subjects are authorised to speak, and which shape the discursive practices they express, the power relations they effect and forms of knowledge upon which they draw” (Schirato et al, 2012). Hence, subject-positions are made available through discourse, and when taken up there may be consequences for subjective experience (Davies & Hare, 1990; Hanna, 2014).

For example, psychologists speak from a particular position of authority that legitimises them to express judgements about clients’ psychological experiences. Their discursive positioning may influence how they experience and relate to their clients as well as their professional identity. Hence the variable ways in which ASPD may be constructed may influence how PPs think, feel and relate towards clients labelled as ASPD and also how PPs think, feel and relate to their own selves as practitioners. This may consequently have implications for their therapeutic identity and subjective experience.

Furthermore, in a Foucauldian context, subjectivity is perceived as ever-fluctuating and changeable (Foucault, 1980). A 'subject' can change its position by repositioning themselves discursively in relation to the 'truth claims' they speak of and thus, they can effect a changing relationship with themselves (Butler, 2005). Hence this study aims to investigate the therapeutic subject-positions that are made available discursively in the PPs' therapeutic accounts of ASPD and highlight what is or is not made available through professional talk. It is proposed that by adopting such a critical gaze, the linguistic limitations and possibilities in relation to the ASPD construct will be exposed.

While the interrogation of the connection between discourse and subjectivity is highly speculative (Willig, 2013; Hanna 2014), it is nonetheless seen as critical for understanding power relations, and thereby it is central in this thesis. The Foucauldian subject-positions will be further considered in Chapter Three (Methodology and Method) and in Chapter Four (Analysis).

1.5 Overview of the aims and the potential contribution of this study

In this introductory Chapter, I have discussed some of the concerns and challenges of the ASPD construct and I have made an argument of why the ASPD problem is worthy of being investigated. Additionally, I have argued that the aim of this study is not to uncover a truth or an objective reality about ASPD and the therapeutic practices related. Rather, this thesis will attempt to create a critical and reflexive space where multiple and diverse understandings of ASPD can be explored and possible power relations implicated within the PPs' professional talk can be investigated.

Within a contemporary context where diverse and often competing expert knowledges influence psychological knowledge and practice, I propose that it is important for Counselling Psychologists, as well as all Psychological Practitioners, to consider and expand the possibilities and limitations of their *position* in the profession. BPS (2005) states that,

It is the responsibility of all Counselling Psychologists to encourage and develop the philosophy of Counselling Psychology (p. 2).

In addition, HPCP (2012) guidelines suggest that CoPs are expected to “reflect critically on their practice and consider alternative ways of working” (HPCP, 2012:13). It is my hope, that this thesis will encourage practitioners to *think critically* and *think differently* about the discursive influences they are subjected to as professionals and consequently how they come to influence their clients through their knowledge and professional standing.

1.6 Introduction to the chapters of this thesis

Having introduced the rationale, the main research question, the epistemological positioning and the methodological approach for this study, the following chapters will address specific issues to support the overall argument that was discussed above. In Chapter Two, I will critically review the relevant literatures adhering to Foucault’s genealogical approach to knowledge. In Chapter Three, I will discuss the poststructuralist epistemology and the methodology and method that were adopted to conduct this study. In Chapter Four, I will examine the research findings in

detail using an FDA approach to interrogate PPs' 'truth claims' about ASPD and its therapeutic applications. Finally, in Chapter Five, I will conclude this thesis by offering a discussion about the implications of these findings and the contribution of this study in the Counselling Psychology as well as in the wider therapeutic community that is interested in ASPD.

CHAPTER TWO

ASPD understandings and therapeutic practices: A Genealogy and Critical Literature Review

2.1 Introduction to Chapter Two

Accounts of ASPD are ubiquitous and pervasive within the domain of Counselling Psychology and the aim of this Chapter is to explore the multiple constructions of ASPD as well as to problematise them within the context of psychological therapies and mental health. More specifically a critical, discursive and socio-historical approach will be applied to: a) trace the pre-psychological ASPD understandings from the ancient times to the 20th century and b) critique contemporary constructions of ASPD drawing upon, psychodynamic, cognitive-behavioural and humanistic knowledges as these orientations are fundamental for most Counselling Psychology trainings in the UK (Woolfe et al, 2010). Furthermore, relevant knowledges such as the biomedical model, the DSM-5 (APA, 2013) and the social constructionist perspective will be considered. Exploring and critiquing these multiple knowledges of ASPD and the relevant therapeutic practices is a central objective of this thesis as Counselling Psychologists are trained and then practice within an integrative or pluralistic framework (Woolfe et al, 2010).

This critical inquiry of the literature will be informed by a Foucauldian genealogical perspective (Foucault, 1997b), which suggests that ASPD is seen as constituted in multiple and mutable ways through socio-historical situated discourses. More particularly, from a Foucauldian perspective, a genealogical inquiry uncovers the historical relationship between truth, knowledge and power (Schirato et al, 2012) and

is of great importance for this study. Hence, a main objective of this chapter is to explore the historic influences on the discursive formation of contemporary knowledges in relation to ASPD in order to “trace its decent” (Malson, 1998: 47) into its present ‘truth claims’. Such a genealogical method to knowledge focuses on the diverse conditions that make certain ideas possible or not possible (Foucault, 1977b; Hook, 2007), and thereby challenges prevalent contemporary norms. Thus, this particular genealogical inquiry aims to highlight the social constructed knowledges related to ASPD and reveal their contingency, as well as interrogate any possible power relations implicated in the various ASPD accounts highlighting what is produced as ‘true’ or ‘false’ and in whose interest.

2.2 Pre-psychological accounts of ASPD

In this section, the pre-psychological constructions of ASPD and related practices will be traced back to the ancient times through to the Middle Ages, the Enlightenment Era, the 19th and 20th century. It is important to acknowledge that although this section is divided chronologically for structural purpose, there is no simple way to identify chronological stages as they “overlap, collide and reappear in different guises” (Rimke & Hunt, 2002: 61). Hence, it is expected that the conceptual shifts of ASPD through time may be blurry and not as clear cut as the chronological stages set out in this section.

2.2.1 Ancient Mesopotamian and ancient Greek ASPD understandings and practices

Modern medical and psychiatric conceptualisations of ASPD can be traced back to the early 19th century but there is very limited earlier literature on this topic (Bertman, 2003; Abdul-Hamid & Stein, 2013). Some historical and archaeological evidence suggests that early understandings of ASPD were evident in ancient Mesopotamia and ancient Greece. Apparently, the first account of ASPD is found in a series of cuneiform tablets known as *Surpu* in ancient Mesopotamia (Abdul-Hamid & Stein, 2013). *Surpu* was a set of religious incantations used by spiritual healers to heal the *sick* (Reiner, 1958). This *healing* took place through beseeching the Gods to “forgive and release the sick, downcast patient who suffers as a consequence of his moral or cultic offences” (Abdul-Hamid & Steiner, 2013: 674).

In this religious text, the *sick* was described by a list of antisocial traits and behaviours that seemed to be a close description of the current contemporary conception of *antisocial* and *psychopathic* individuals (Kinnier-Wilson, 1965). Kinnier-Wilson (1965), an archaeologist writes about this *Surpu* text,

here is the Babylonian psychopath - the pathological liar, the swindler, the kleptomaniac, the gossip monger, the social misfit, the sexual, the murderer - an unmistakable picture (p. 924).

This religious text was studied and compared to DSM and ICD descriptions of ASPD (Abdul-Hamid & Stein, 2013) and it was concluded that there are striking similarities between the Mesopotamian and contemporary descriptions of ASPD. From a discursive and socio-historical perspective, it is particularly interesting that what

seems to have been described as ASPD in ancient Mesopotamia was understood as a *spiritual illness*, which suggested that antisocial individuals at that time were seen as possessed and thus in a sense *evil*. This discursive construction of ASPD authorised the institution of religion to make claims upon those seen as *ill* and *evil* as well as their 'healing' through spiritual practices, such as *Surpu*, perhaps a form of ancient exorcism.

Furthermore, some descriptions of the characteristics that now inform contemporary conceptions of ASPD are found in Ancient Greece (Millon et al, 2003). Theophrastus (371 BC-287 BC), a student of Aristotle, who was well known for his apt descriptions of personality types (Chisholm, 1911), described in his book *Characters, The Unscrupulous Man*, seemingly a close description to current understandings of the ASPD. He wrote,

The Unscrupulous Man will go and borrow more money from a creditor he has never paid...When marketing he reminds the butcher of some service he has rendered him and, standing near the scales, throws in some meat, if he can, and a soup-bone. If he succeeds, so much the better; if not he will snatch a piece of tripe and go off laughing (cited in Widiger et al, 1991: 63).

Early Greeks also introduced the medical practice of Humorism, which not only replaced the ancient theories about demonic possession (Bennet, 2003) but also became one of the first systems to explain differences in personalities (Millon et al, 2004). Hippocrates (460 BC-370 BC), the father of medicine, proposed that all disease (physical or mental) stemmed from an excess or imbalance among four bodily humours: yellow bile, black bile, blood and phlegm (Bennet, 2003). Hippocrates further identified four corresponding temperaments: the choleric, melancholic, sanguine and

phlegmatic that centuries later were associated with particular personality traits by Galen⁴ (Steiner, 2008). The most relevant to the genealogical inquiry of ASPD is the choleric temperament that was associated with irascibility, impulsivity, aggression, egocentricity (Eysenck, 1967; Childs, 2009) some of 'prevalent' characteristic in contemporary descriptions of ASPD.

In contrast to the ancient Mesopotamian accounts, it seems that ancient Greek accounts described *illness* as having a biological base. In that context, different personality styles as well as difficulties were constructed as a problem of the body. The dominance of the medical discourse legitimised the ancient Greeks medical doctors to define personality *health* and *illness* and to perform medical practices such as bleeding and purging as a way of *treating* personality problems. Hence, the materiality of the body was privileged over the mind which seemed to be subsumed in the human physicality.

2.2.2 Madness in Middle Ages (5th-15th Centuries)

Despite the paucity of historic evidence about ASPD descriptions, understandings and practices during the Middle Ages and the Enlightenment Era (see section 2.2.3), in accordance to the genealogical stance taken by this study, relevant knowledges and practices about *madness* and *dangerousness*⁵ during these historic periods are of immense importance as they might reveal some of the prevalent discursive resources that later informed modernist ideas about ASPD.

⁴ The choleric temperament was associated with irascibility, the sanguine temperament with optimism, the melancholic temperament with sadness and the phlegmatic temperament with apathy.

⁵ See section 2.2.3.

Modernist discourses about *madness accounts* in the Middle Ages, highlight contradictions in terms of how *madness* was understood and managed during this historic period (Harper, 1997). Some paint a cruel, unreasonable and superstitious picture of medieval *insanity* perceptions and practices (Zilboorg, 1941) whilst others, including Foucault (1976), argue that *madness* was a ‘free trade’. Foucault (1976) writes in his earliest work, *Mental Illness and Psychology*, that *madness* in Medieval Times “was allowed free reign; it circulated throughout society, it formed part of the background and language of everyday life” (p. 67). Such contradictory accounts reveal the complexities of the historic influences on the formation of contemporary psychological knowledges.

In Middle Ages in Europe, where Christian society perceived the world to be under a constant struggle between good and evil, conceptions of *madness* were a combination of the divine, diabolical, magical and transcendental (Roffe, 2013). Christian formulations of *madness* saw it as a “moral malady” (Roffe, 2013: 27) or a punishment for a sin or a test of faith. Christian ideology endorsed spiritual remedies for *madness* such as fasting, prayer and exorcism (Laffey, 2003). Thus, *madness* at that time, was heavily defined and regulated by religion institution.

Despite the significant influence of Christianity on understandings of *insanity* this was not the only prevalent perception, especially in medieval England (Roffe, 2013). There is remarkable evidence to suggest that a biological understanding of *mental illness* was also popular (Kroll & Barchard, 1984; Roffe, 2013). The medical practice of Humorism⁶ was still common during the Middles Ages and practices such as blood-letting and purging through laxatives were used to balance the bodily fluids

⁶ See Chapter Two Section: 2.2.1

in order to treat *mental illness* (MacDonald, 1981). The construction of *madness* as a body disorder also legitimised the regime of classical medicine to perform basic treatments - dietary, herbal and surgical (Clarke, 1975).

The recognition of *mental illness* as a body disorder also enabled the state to intervene in the regulation and management of the *mentally ill* (Roffe & Roffe, 1995). Although in medieval England family was seen as the primary source of care for those deemed as *lunatics*, sometime during the reign of Henry III (1216 -1272) the crown assumed the right to guard the *mentally ill*, whose families could not look after (Roffe & Roffe, 1995). As historic critics argue, this was not a medieval welfare system but a “predatory feudal kingship extending its rights to wardship where personal service could not be rendered” (Roffe, 2013: 27). Perhaps this predatory nature of the crown’s interest in the regulation of the *mentally ill* was highlighted in the process of assessment which was open only to those who had personal or real estate.

The historic landscape in the Middle Ages reveals that similarly to ancient times *madness* seemed to be defined and regulated by the dominant disciples of religion, classic medicine and, additionally, the state. Perhaps the domination of those forces was symbolised in the foundation of Bethlem (later renamed as Bedlam) in 1247 by Henry II, which was the first psychiatric institution of its time (MacDonald, 1981). *Bedlam*⁷, meaning chaos/uproar, possibly highlighted the chaos and uncertainty about *madness* and its management during these times.

⁷ ‘Bedlam’ meaning chaos/uproar, is thought of having entered the English language coming from the hospital Betlem.

2.2.3 *Madness and dangerousness in the Enlightenment Era (16th to 18th Centuries)*

During the Enlightenment period a major intellectual shift took place: from religious orthodoxy to scientific inquiry. By the end of the 17th century and into the Enlightenment with the scientific discourse influencing the formation of new ideas, *insanity* was increasingly seen as an organic physical phenomenon rather than a spiritual matter (Porter, 2002). The humoral theory, that was prevalent for centuries, gave way to new systems of classifications and categorisations that constructed human experiences in its totality as an object of the uprising scientific discourse. With the scientific valorisation of objective reason or unreason, *madness* was objectified as a natural object worthy of study and treatment by the leading entrepreneurs of that time, the medical doctors.

Foucault (1961) himself, studied conceptions of *madness* during Renaissance, and argued that although the *mad* were depicted in art as possessing a kind of wisdom, the wider societal response to them at the time was that of confinement. Hence, the *mad* became outcasts to be marginalised. Foucault (1961) described this process as the 'Great Confinement' and wrote,

...modern man no longer communicates with the madman [...] There is no common language: or rather, it no longer exists; the constitution of madness as mental illness, at the end of the eighteenth century, bears witness to a rupture in a dialogue, gives the separation as already enacted, and expels from the memory all those imperfect words, of no fixed syntax, spoken falteringly, in which the exchange between madness and reason was carried out. The language of psychiatry, which is a monologue by reason *about* madness, could only have come into existence in such a silence (p. 27).

Foucault (1961; 1976) saw the social forces as an extra-judicial mechanism at the forefront of confinement, that was legitimised and invested in order to *eradicate* the *mad* who in this process of exclusion they became the 'other'.

The 'Great Confinement' led to the management of populations through the birth of the asylums. Asylums were considered at the time as a significant advance in medical practice and a great 'philanthropic gesture' that promoted more humane treatment of the *mad* (McNay, 1994). However, in Foucault's view, asylums constituted a more insidious form of control over the *mad* that was exercised through the deployment of a judgemental and moralising ethos (McNay, 1994). Foucault also argued that during the same time *madness* or *mental disorder* came gradually to include dangerous people which was not only significant in "the history of criminal psychiatry, but also for the history of psychiatry *tout court* and ultimately for the human sciences" (Foucault, 2003: 113). This shift legitimised the psychiatric domain to gradually establish its involvement in *managing* and *treating* not only the *mad* and but also the *dangerous*.

This gradual convergence of concepts of *madness* and *dangerousness* is highly relevant for this study as it lays out the historical and discursive arena for contemporary ASPD psychological knowledges and practices. As David Jones (2016) writes in his book *Disordered Personalities and Crime*, "crudely put, the story comes down to the three diagnoses of 'moral insanity', 'psychopathy' and 'antisocial personality disorder'" (p. 3). These three diagnoses came to prominence in the early decades of 19th century, the latter decades of the 19th century and the middle of 20th century respectively (Jones, 2016). Before critically reviewing these diagnoses, I will briefly consider the influence of the 'public sphere', the media and press, the legal system and the medical

profession in the eighteenth-century Britain on the formation of ideas about *moral insanity*.

2.2.4 Madness in the 18th Century Britain

2.2.4a The emergence of the 'public sphere' and the new social order.

During the eighteenth century significant social, political and economic changes took place in Britain. The urbanisation, the industrialisation, the development of capitalism, the increasing liberty of the press (Holmes, 1969) and the emergence of new social and political forces promoted increasingly secular understandings of humans and the world around them (MacDonald, 1981) limiting gradually the power of the religious discourse. In this new developing society, traditional values were questioned and new socio-cultural norms, attitudes and practices arose giving birth to a new historic era that of 'modernity' (Giddens, 1990; Porter, 2000).

Habermas (1991), in his publication *The Structural Transformation of the Public Sphere*, identified the origins of the development of the 'public sphere' in Britain during this time. He suggested that the socio-political and economic changes mentioned above as well as the increased freedom of the press and the growing *bourgeois* brought about a crucial transformation in how people thought about themselves and their worlds (Habermas, 1991). The relationship between the individual and the social world was reframed and at the same time 'the mind' came to occupy a significant place as an object of study (Jones, 2016). This reconceptualisation enabled the formation of more nuanced theories of *insanity* including that of *moral insanity* (Jones, 2016). During this time, the term 'moral', which was connected to ethical aspects or human

behaviour and the religious discourse, came to gradually encompass a more psychological meaning and more particularly the concept of feelings and affects at the end of the eighteenth century (Millon et al, 2003). This emerging 'modern state' required new understandings of individual psychology and new ways of relating to social order (Elias, 1994) and the development of the 'public sphere' enabled a new space for the dissemination and exploration of such new ideas. This meant that new and cutting edge psychological advances were explored and discussed outside of the private academic circles (Reed, 1997). Hence, the 'public sphere' played a central role in enabling public discussions and debates that were essential in the emergence and construction of new ideas about *moral insanity* (Jones, 2016).

2.2.4b The role of media and the press.

The development of diverse channels and forms of media communication impacted significantly on the construction of new ideas about *sanity* and *insanity*. The media and the press enabled the creation of a new 'space' where ideas about *madness* could be accessed easily and could also be discussed and debated. By reporting debates and legal cases about *madness*, criminal responsibility and physiology (MacDonald, 1988) they promoted and stimulated reflection on human nature and human society contributing significantly on the development of the 'plebeian public sphere' (Calhoun, 1992: 38). These debates were further enabled due to the proliferation of newspapers and the publication of books (Black, 1987) as well as other intellectual advances such as the novel. For example, the development of the novel from the mid-eighteenth century encouraged the consideration and exploration of the human 'mind' and internal psychological life. As Jones (2016) argues the novel

became “a significant cultural vehicle that allowed for innovative ways of understanding individual psychology” (p.12). Hence, these intellectual and cultural advances cultivated a new knowledge space that forged an interest in understanding human psychology and at the same time allowed for the dissemination of such interest across communities.

2.2.4c The role of the law and the medics.

Within the emergent modern state in the eighteenth century, the development of a centralised and more specialised legal system that was able to intervene in crime as well as the growing interest in understanding various emotional aspects of human relationships encouraged the consideration of more subtle forms of *insanity* in the court (Jones, 2016). The consideration of *insanity* in a number of legal cases at the time suggested that the legal system was positioned a dominant expert knowledge in this significant area at the time. Although there were medical professionals that claimed expertise upon insanity at the time, medical experts were not involved in court trails (Jones, 2016). It was only in the nineteenth century that medical professionals claimed expertise upon *insanity* in the courtrooms (Porter, 2002). This shift coincided with the emergence of psychiatry that was not recognised as a medical specialism during the eighteenth century (Porter, 1987). Psychiatry as an emerging expert power offered a different approach to moral insanity and its treatment to the prevalent legal discourse of the time. The following section will consider the development of the psychiatric discourse and its role in the construction of new concepts of *insanity* such as *moral insanity*, *psychopathy* and finally *antisocial personality disorder*.

2.2.5 Early psychiatric influences in early and mid-19th Century: The emergence of *moral insanity*

The birth of psychiatry as a medical specialism is located by many in the nineteenth century (Porter, 1987; Scull, 1979b; McCallum, 2001; Jones, 2016) and it was not until well in the nineteenth century that psychiatry was recognised on an institutional level (Jones, 2016). The medical advances during this time and the gradual displacement of the religious doctrine by the scientific regime warranted psychiatrists, “the entrepreneurs of the moral world” (Jones, 2016: 50) not only to define *moral insanity* but also to claim expertise upon the minds of the *morally insane* and their treatment (Watson, 2011). The development of *moral treatment* became a vehicle for recognising the emergent profession of psychiatry and at the same time established its power through the promotion of psychiatric expert knowledge in scientific journals and the widespread construction of psychiatric asylums (Jones, 2016).

Philippe Pinel, a French physician, was closely associated with the development of *moral treatment*. It was his work (Pinel, 1801/1962) that contributed significantly to the connection of emotional disturbance to immorality (Augstein, 2003; Schirmann, 2013). His work described a form of *madness* referred to at the time as *folie raisonnante* and noted that some of his patients engaged in impulsive and destructive acts, despite the fact that their reasoning abilities were not impaired (Millon et al, 2003). Pinel’s concept *manie sans delire*, insanity without delusion, became highly influential and formed a base for contemporary understandings of personality disorders (Sass & Herpertz, 1995) and in particular ASPD (Horley, 2014).

Following Pinel’s contribution, Thomas Arnold and Benjamin Rush were the first to use the term *moral insanity* to describe *madness* as a result of a disruption or

perversion of emotions or moral sense. Rush (1812) wrote in particular about the *perversion of the moral faculties* and described cases characterised by clarity of thought in combination with socially deranged behaviours. He constructed these individuals as possessing “an innate preternatural moral depravity” in which “there is probably original defective organisation in those parts of the body which are preoccupied by the moral faculties of the mind” (Rush, 1812: 112). Rush was the first to turn Pinel’s morally neutral clinical observation of affect defects into a social condemnation (Augstein, 2003; Milon et al, 2003). He wrote,

The will might be deranged even in many instances of persons of sound understandings...the will becoming the involuntary vehicle of vicious actions through the instrumentality of the passions. Persons thus diseased cannot speak the truth upon any subject...Their Falsehoods are seldom calculated to injure anybody but themselves (Rush, 1812: 124).

Furthermore, Esquirol’s work, a highly influential student of Pinel, promoted the idea that “it was possible for acts of violence to be carried out by people who had all outwards signs of normality but were driven by some flawed belief or impulse” (Jones, 2016: 55). Esquirol (1819) introduced the concept of *monomania* (from the Greek *monos* meaning, one, and *mania*, meaning madness) and described “a form of partial insanity conceived as a single pathological preoccupation in an otherwise sound mind” (Goldstein, 2002: 115). Esquirol’s (1838) theory of monomania suggested that a single behavioural disturbance could be the only diagnostic criterion for a disorder (e.g. pyromania, kleptomania, homicidal monomania). His work contributed significantly in the recognition of the psychiatric profession at the time (Goldstein, 1998). Esquirol’s concept of monomania not only emboldened the scientific understanding of the mind

but also implied the need of medical expertise in order to detect this subtle manifestation (Jones, 2016).

At the same time, issues of monomania became prominent in Britain. The British physician, James Cowles Pritchard (1835) influenced by Pinel's and Esquirol's contributions, was the first to formulate the concept of *moral insanity*. Pritchard's *moral insanity* differed significantly from *monomania* or *partial insanity*. Pritchard (1835) suggested that the *morally insane* patients afflicted by this *disease* were *defective* in the sense that they did not have any sense of rightness, goodness and responsibility, and despite their ability to understand the consequences of their acts they seem to engage in repugnant social behaviours. He defined *moral insanity* as,

a morbid perversion of natural feelings, affections, inclinations, temper habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination (Pritchard, 1835, as cited in Sass & Herpertz, 1995: 635).

In Pritchard's view, "these behaviours signified a reprehensible defect in character that deserved social condemnation" (Millon et al, 2003: 7). It is of great interest as Augstein's (1996) observed that Pritchard developed such a radical theory, whilst he fostered a deep Christian belief/connection. It is important to mention that Pritchard's work was highly influential for the development of modern psychopathic constructs, especially in the UK where his definition of *moral insanity* led to the *moral imbeciles* of the English Mental Deficiency Act in 1913 and the *moral defects* of the Mental Deficiency Act in 1927 (Gunn, 2003).

The psychiatric influences described above meant that immorality was no longer understood as related to religion but as a mental disorder. The birth of *moral*

insanity suggested that *moral disease* was an “abnormal phenomenon to be mastered by rationalising science” (Rimke & Hunt, 2002). Thus, “immorality was transformed from sin to an effect of insanity” (Schirmann, 2013: 34), a process described by Rimke and Hunt (2002) as the “medical model of vice pathology” (p. 80). Foucault’s idea of ‘dividing practices’ (Foucault, 1982), suggested that the diagnosis of *moral insanity* did not only serve the purpose of distinguishing those who posed a threat to social order rather it aimed to ‘divide’ such individuals from the populations at large. In a Foucauldian sense, ‘the clinic’ (Foucault, 1963) and ‘the prison’ (Foucault, 1977) became central power mechanisms in the segregation and regulation of populations.

The dominance of psychiatry in the construction of *moral insanity* signified an important discursive and historic shift: from moral codes and the religious discourse to *moral insanity* and the prevalence of the medical discourse (Rimke & Hunt, 2002). The development of formal ideas of *moral insanity*, and related ones such as monomania, in the first half of the nineteenth century not only marked the birth of the psychiatric discipline but also enabled the emerging profession of psychiatry to assume a high-status position in the criminal courts of that time by claiming expertise in detecting ‘forms of insanity that damaged the capacity for affective, or moral, understanding’ (Jones, 2016: 16). For some decades, the psychiatric expertise was highly influential in a number of trials verdict in the UK (McCallum, 2001). However, the cases of M’Nagthen in 1843 and Townley in 1863 as well as the press responses and public opinion towards these criminal cases lead to the abandonment of the *moral insanity* concept in the criminal courts (Jones, 2016).

Following the ‘dislocation’ of the psychiatric expertise from the courtrooms, psychiatry turned its interest in developing classification systems by measuring and identifying criminal cases and types in the growing populations of prison and asylum

institutions (McCallum, 2001; Jones, 2016). Within this developing essentialist climate of psychiatry, brain-based explanations for immorality came to light that promoted the idea that *moral insanity* was linked to brain dysfunction (Verplaetse, 2004). *Moral insanity* came to be increasingly seen as a form of genetically-inherited degeneracy (Verplaetse, 2004; 2009), reminiscent of the Darwinian construction of morality as a sign of complex species development. Hence, the discursive construct of *moral insanity* signified the medicalisation of *madness* and *badness* and legitimised the regulation of those determined as *mad* and *bad* by the psychiatric domain. A complex discursive transition has begun in this century: from sin to degeneration.

2.2.6 Early psychiatric influences in the late 19th and early 20th Century: The emergence of *psychopathy*

With the prevalence of the medical discourse at the end of the 19th century, psychiatry positioned itself as “an active moral police force” (Rimke & Hunt, 2002: 79) in regulating individuals who struggled to govern themselves. In the UK, Maudsley (1874), a renowned British psychiatrist interested in the degeneration theory, developed the concept of *moral imbecility* (Maudsley, 1874) referring to a subcategory of offenders that was “marked by a defective physical and mental organisation...which really determines their destiny in life, being an extreme deficiency or complete absence of moral sense” (Maudsley, 1874: 32). Maudsley’s (1874) understanding of *moral imbecility*, otherwise known as *criminal psychosis*, suggested a genetic origin and imperviousness to punishment (Milon et al, 2003).

During the same time, German psychiatrists established medical models of *moral insanity*, which were gradually replaced by *psychopathy*, described by some as

an elusive category (Lewis, 1974). A leading figure of that movement was Julius Koch (1841-1908), a German psychiatrist and philosopher, who coined the term *psychopathic inferiority* to include all mental irregularities or impairments crystallising his belief that the basis of any mental dysfunction was biological (Koch, 1891). Koch's description of a series of dysfunctional long-term ways of being eventually became known as personality disorders (Horley, 2014) and formed the base for contemporary understandings of ASPD. Furthermore, the work of Adolf Meyer (1904), an American psychiatrist, added further to the medical discourse of *psychopathy* by introducing the concept of *constitutional inferiority*. Meyer (1904) aimed to separate psychotic from neurotic disorders and was convinced that although neurotic disorders were primarily psychogenic, the psychopathic disorders were inherent by physical defects or *constitutional inferiorities*.

Towards the end of the 19th century, Pontoppidan's (1895) theoretical contribution of abnormal personalities and the 'anatomically degenerated' man supported further the medical discourse of *psychopathy*. Additionally, Lombroso's (1876) idea of the *born delinquent* as well as Gouster's (1878) conception of *stigmata* enhanced the medicalisation of *psychopathy*. These concepts proposed openly a biological basis for *immorality* and according to some, they seem to correspond strikingly with the DSM-5 (APA, 2013) criteria for ASPD (Millon et al, 2003).

At the turn of the century, Emil Kraepelin (1856-1926), a renowned psychiatric nosologist, wrote about *psychopathic personalities* (Kraepelin, 1907), which included akin features to what it is termed today as ASPD. Kraepelin initially identified four different *psychopathic personality* types ('morbid liars and swindlers', 'criminals by impulse', 'professional criminals' and 'morbid vagabonds'). Later in his work, Kraepelin (1915) understood *psychopaths* as deficient in affect or volition and proposed two

broad categories: those of morbid disposition and those exhibiting personality peculiarities. The latter category included seven personality subtypes: the excitable, the unstable, the impulsive, the eccentric, the liars and swindlers, the antisocial and the quarrelsome (Kraepelin, 1915). Millon et al (2003) note that the last three subtypes possess features similar to current notions of ASPD.

The British concept of *psychopathy* was shaped by Henderson (1939) who understood psychopathic states as a condition of *constitutional abnormality*. In contrast to the medical discourse, Henderson (1939) suggested that heredity and environment played an equally significant role in the constitution of *psychopathy*. Henderson's (1939) work suggested that *psychopathy* was intrinsically social in nature. Henderson (1939) inheriting a social approach on understanding individual deemed as *psychopaths* wrote,

Their story is often not listened to, or if it is, it is not given a great deal of credence; and in any case there is no provision, so why not lock him up in prison or hang him and be done with him? It is not to be wondered at that, under such circumstances, the aggressive psychopath becomes bitter, hates society and himself and attempts to square accounts by whatever impulses, for the moment, in the ascendant (p. 46).

Another example of a social approach in constructing *psychopathy* was the term *sociopathy* introduced by Partridge (1930), an American psychologist. *Sociopathy* also suggested the social origin of the problem. Henderson's and Partridge's ideas about the influence of social environment on *psychopathy* perhaps formed the ideological base for contemporary social constructionist understandings of this problem.

Furthermore, post-World War I, Kurt Schneider (1923), an eminent German psychiatrist, advocated for a value-free approach to the psychopathy problem and defined *abnormal personalities* as statistical deviations. Schneider distinguished “two forms of psychopaths: those who suffer from their psychic abnormality, and those from whom society suffers” (Herpertz & Sass, 2002). He also observed that individuals that thought to have psychopathic traits did not necessarily become criminals but lived at large in society and were usually successful in political or material power (Schneider, 1958). Schneider’s understating seemed to be close to contemporary conception of the *successful psychopath* further developed by Cleckley’s (1941), another psychiatrist. In his book, *The Mask of Insanity*, Cleckley (1941) offered a detailed description of the psychopathic personality who can be found outside of prisons and in highly successful and respectable positions such as businessmen, scientists, physicians and psychiatrists. Cleckley (1941) wrote,

In these personalities...a very deep seated disorder often exists. The true difference between them and the psychopaths who continually go to jails or the psychiatric hospitals is that they keep up a far better and more consistent outward appearance of being normal. The chief difference...lies perhaps in whether the mask or façade of psychobiologic health is extended into superficial material success (p. 198-199).

These dominant psychiatric influences constructed a new understanding of *psychopathy* that included not only the typical criminals who break the law and end up in confinement but highly intelligent and ‘powerful’ individuals who were respected and praised by society.

The multiple constructions discussed above, reveal the historic shifts in the discursive development of ASPD. During this historic time, *moral insanity* gave way to *psychopathy*, which was mainly understood as having a biological basis. This construction legitimised the psychiatric regime to establish its involvement in the production of *psychopathic subjects* and their management. Hence, the dominance of the psychiatric discourse privileged a set of power relations where the 'expert' psychiatrists were enabled to make claims upon the minds of the 'dangerous' psychopathic individuals.

Furthermore, psychopathy came to have a place in the 1959 Mental Health Act (Rollin, 1963). The problem of psychopathy and the detention of individuals that were deemed as psychopathic and dangerous raised debates as to whether psychiatry was to be solely responsible for making decisions for the treatment of such individuals (McCallum, 2001). After numerous debates, it was decided that psychopathy would be included in legislation as 'persistent disorder or disability of mind' which resulted in 'abnormally aggressive or seriously irresponsible conduct susceptible to medical treatment' (DoH 1959: Part1, Point4, as cited in Jones, 2016). The recognition of psychopathy as a legal category reveals the complex interplay between the dominant disciplines of law and psychiatry in claiming expertise in this significant area.

At the same time the development of psychology as an expert knowledge domain, the formation of new psychoanalytic ideas in relation to *psychopathy* and criminal behaviour (Reich, 1925; Alexander, 1935; Karpman, 1941; Fenichel, 1945) and the social/interpersonal models of antisocial personality (Leary, 1957) gave way to the emergence of psychological discourses that would become highly influential in the development of contemporary ASPD understandings throughout the mid-20th century to date. The new psychological advances enabled psychological practitioners

to claim expertise upon ASPD and establish their own position of power within this significant area. It is important to acknowledge the power struggle that emerges for Counselling Psychology as an expert knowledge. Amongst other disciplines, Counselling Psychology seems to be engaging in a contemporary 'battle' vying for power, recognition and expertise in the ASPD area. The following section will discuss and critique some of significant psychological knowledge influences in relation to ASPD with a particular interest in their relevance to Counselling Psychology.

2.3 Contemporary psychological constructions of ASPD

As discussed in Chapter One (see section 1.2), ASPD as a construct is relatively new and was introduced as an official diagnostic category in DSM-2 (APA, 1968). This section will explore and interrogate contemporary ASPD psychological knowledges and practices beginning with the contribution of Freud and early psychoanalysts, moving to the cognitive behavioural theory, the biomedical model, the humanistic approach and finally the social constructionist paradigm. The various constructions of ASPD and relevant therapeutic practices will be considered and problematised in the context of Counselling Psychology.

2.3.1 Psychodynamic Perspectives of ASPD

Psychodynamic theory as a knowledge domain is widely constituted by numerous theoretical perspectives. This subsection will consider some of the most influential psychodynamic perspectives on personality disorders and particularly ASPD, beginning with Freud, moving to Object Relations School and finally considering Attachment Theory.

2.3.1a The Classical Psychoanalytic View of ASPD.

Freud's (1856-1939) development of psychoanalysis, the 'talking cure', constituted a new and highly influential discursive field of its time and marked an important conceptual shift in the production of psychological knowledge and practice. Freud understood psychopathology as the conflict between unconscious drives and internal prohibitions of these drives (Yeomans & Levy, 2002). He proposed a structural model of the 'psyche' which was concerned with the development and disturbance of personality (Freud, 1923). Freud saw personality as structured into three parts: the id, ego and superego. The Id was understood as dominated by unconscious, primitive instincts, including the sex instinct (Eros) and the aggressive instinct (Thanatos); the Superego incorporated the societal values and morals which are learnt from significant others; and the ego was seen as developing to mediate between the instinctual id and the external real world, represented by Superego (Freud, 1923). Within a Freudian context normal development of personality "works towards the delay of self-centered immediate gratification" (Millon et al, 2004: 166) and in this process a well-developed superego constrains immediate gratification through the introjection of moral principles and values (Millon et al, 2004).

Freud himself devoted little time and thought to understanding the antisocial mind (Meloy & Shiva, 2007) but he recognised that amongst criminals there are individuals who

commit crimes without any sense of guilt, who either have developed no moral inhibitions or who, in their conflict with society, consider themselves justified in their actions (Freud, 1916/1925c: 333).

Freud (1928) further suggested that,

Two traits are essential in the criminal: boundless egoism and a strong destructive urge. Common to both of these, and necessary condition for their expression, is absence, lack of an emotional appreciation of (human) object (p. 178).

Many early psychoanalysts, inspired by Freud's psychoanalytic theory wrote about delinquency and antisocial personality. Aichorn (1925) was the first analyst to examine delinquent behaviour and suggested that delinquency was a result of a *defective superego* and the individual's failure to internalise parental norms and social values during childhood. Similarly, Abraham's (1925/1927) analysis of *an impostor* and Reich's (1925) *impulsive character* supported the same view asserting that the superego in antisocial personalities failed to restrain the id impulses and gain expression through the ego's controls. Additionally, Alexander (1930; 1935), who was the first psychoanalyst to explore psychopathy and criminal behaviour, described the *neurotic character* which was seen as underlying psychopathic states. In Alexander's view this character description demonstrated diminishing levels of ego's ability to control unconscious impulses leading to antisocial and criminal behaviours.

Hence, from a classical psychoanalytic perspective, ASPD is understood as a result of the interplay of id-ego-superego: the ego develops but the superego remains undeveloped. Instead the total personality remains dominated by the id and its pleasure principle (Fenichel, 1945; Friedlander, 1945). This psychoanalytic understanding of ASDP further suggests that defence mechanisms are sparse as antisocials are seen as impervious to shame or guilt (Stone, 1993) and rather characterised by a lack of conscience (Millon et al, 2004). Thus, the *antisocial* individual is objectified as egotistical, centered in his/her own immediate needs and

gratification, and totally dominated by instinctual forces. In a sense, the *antisocial subject* seems to personify the id; absorbed by its own desires, urges and impulses the societal standards and norms are irrelevant and unimportant.

Classical psychoanalytic theory was mainly resourced by the medical model and it positioned itself to explain and 'treat' problems that were unresolved medically at the time. A classical psychoanalytic view of ASPD suggests a set of power relations where the analyst, the 'expert' (Foucault, 1980), could decipher unconscious intrapsychic processes and communication and interpret the hidden meaning behind antisocial behaviours. This assumes that the 'expert' can have an 'objective' opinion over the client's experience who is positioned as unknown to themselves (Foucault, 1982) and reliant to the analyst's expertise.

2.3.1b The Object Relations view of ASPD.

The Object Relations theory is a further development of the psychoanalytic Freudian theory. Object Relational theorists and clinicians, such as Ferenczi, Guntrip, Klein, Winnicott suggested a more relational view of psychopathology. This view emphasised that the unconscious drives "are not experienced in the psyche in a void, but in relation to a specific other, an object" (Yeomans & Levy, 2002: 76). The psychic structure is made up by basic building blocks of psychological structures termed *internal object relations*. Kernberg and Caligor (2005) write that,

An internalised object relation consists of a particular affect state linked to an image of a specific interaction between the self and another person (e.g. fear, linked to the image of a small terrified self and a powerful, threatening authority figure) (p. 116).

In infancy, the internal world of a child is characterised by splitting. The child relates to internal objects as totally good or totally bad, oscillating between ideal providers to sadistic persecutors (Kernberg, 1995). With the support of caring others, in this instance mainly the mother figure, the child integrates split internal images and to 'good enough' other position, termed by Klein (1946) as the 'depressive position'. If the individual does not manage the psychological integration then she/he remains in the split internal organisation, otherwise known as 'paranoid schizoid position' (Klein, 1946).

An object-relational understanding of ASPD would suggest that "internalised objects remain part-objects in the sense that good and bad aspects are not integrated into a whole object or representation" (Meloy & Shiva, 2007: 343). Hence, the self and others are seen as either good or bad and this is maintained by primitive defences, such as splitting or projection identification (Meloy & Shiva, 2007). In such an internal psychic organisation, there is an absence of conscience and also complex *mature* emotions, such as fear, guilt, empathy, depression, sadness, loneliness, reciprocal joy (Kernberg, 1984).

More specifically within the object relations context, Otto Kernberg (1970; 1984; 1989) reconceptualised ASPD and understood it as possessing fundamental features of narcissistic personality in addition to the unusual pathological sense of morality (Kernberg, 1989). Kernberg (1989) proposed a special syndrome, he termed *malignant narcissism*, also termed in the literature as the *traumatic narcissist* (Shaw, 2014), that is characterised by a combination of the following: a) a narcissistic

personality disorder, b) antisocial behaviour, c) ego-syntonic aggression⁸ or sadism and 4) strong paranoid thinking.

Similarly, to the classical psychoanalytic perspective, this view of personality psychopathology and more particularly ASPD, assumes that the problem lies in the individual's internal world. Although, this approach implicates relational aspects of personality development, suggesting that relationships with others play a significant role in human psychological health or disturbance, the phenomenon of ASPD is very much understood as a result of intrapsychic unconscious processes. For example, the ASPD individual is objectified as deficient in their ability to develop mature emotions or defences or is seen as stuck in an internal realm dominated by persecutory or narcissistic fantasies. As some object-relational clinicians claim,

the central motivation of the psychopath is to dominate his objects. There is no desire for affectional relating. Nor reciprocal altruism. He operates from within a dominance-submission paradigm, and identifies in a conflict free manner with the predator (Meloy & Shiva, 2007: 339).

I would suggest that this view is particularly damning, painting a demonising picture of such individuals. Such understanding promotes a deeply pathologising understanding of the ASPD individual, obscuring other possible understandings of ASPD that may be resourced from the social and cultural sphere. At the same time, in clinical practice, this view may suggest a set of power relations where the 'good' therapist may be objectified and 'used' by such clients precluding further consideration of the therapist's influence on therapeutic interaction with clients deemed as ASPD.

⁸ Egosyntonic is a psychoanalytic term referring to behaviours, values, and feelings that are in agreement with the needs and goals of the ego, or consistent with one's ideal self-image.

2.3.1c The Attachment Theory view of ASPD.

Attachment Theory, was developed by the British Psychoanalyst John Bowlby and has become particularly influential on contemporary theoretical and treatment developments of personality disorders. Mentalisation-based therapy, which is commonly provided in the NHS and prison personality disorder services, is rooted in Bowlby's Attachment Theory and will be discussed later in this subsection.

Bowlby (1950; 1969; 1973), inspired by ethology and particularly Lorenz's work on the phenomenon of imprinting, conceptualised and researched human attachment behaviour introducing new and highly controversial psychoanalytic ideas at the time. Having taken a particular interest in Darwinian ideas about evolution, Bowlby saw attachment as a biologically-based behavioural system, which served as an evolutionary survival mechanism for protection of the infant by maintaining closeness to the caretaker (Coates, 2012). The infant's expression of object-seeking through behaviours such as sucking, clinging, following and crying, aimed to bring the infant closer to the mother. According to attachment theory, it is during this early time that the fundamentals of object permanence and object representation are observed (Meloy & Shiva, 2007).

From this perspective, attachment is seen as a strong affectional bond present both in children and adults, and most human beings with the requisite biology and loving parents will develop secure attachments as they grow up (Cassidy & Shaver, 1999). Bowlby (1969) identified pathologies of attachment which were typically labelled as: fearful, preoccupied, disorganised and dismissive (Meloy, 2002). The latter attachment style seems to be the most relevant to ASPD as it is characterised by detachment, apathy, lack of emotions, self-absorption, and preoccupation with non-

human objects (Bowlby, 1969). Bowlby (1944) described this attachment style as *affectionless psychopathy* in a research sample of juvenile offenders and attributed its cause to constant maternal rejection. Further research has suggested that this pathology of attachment is correlated with conduct disorder and ASPD (Allen et al, 1996).

Furthermore, Mentalisation-based Therapy (MBT), a modified psychodynamic psychotherapy developed by Peter Fonagy and Anthony Bateman originally for Borderline Personality Disorder (BPD) (Bateman & Fonagy, 1999), has taken an interest in conceptualising and treating ASPD. Similarly, to attachment theory, MBT offers a bio-psychosocial understanding of ASPD, which is seen as arising from an interaction between genes and the environment with a particular emphasis to mentalisation, the individual's ability to think about his/her mental state as well as the mental states of others (Fonagy & Target, 1997). From this perspective, ASPD can be understood

as a disorder of attachment in which genetic precursors interacting with early environmental adversity result in abnormal personality development, particularly in areas of affect regulation, impulse control and, [...] the ability to mentalise (McGauley et al, 2011: 377).

In this developmental model of ASPD it is suggested that the interaction of adverse environments with genetic predisposition results in pathological attachment, inability to self-regulate and mentalise (Fonagy, 2003b; Levinson & Fonagy, 2004). Hence, in this context treatment primarily aims to help the client regulate affective states and develop the capacity to mentalise.

Attachment theory and MBT, as expert knowledges, seem to be resourced by a bio-psychosocial discourse. In this developmental model, ASPD is essentialised as a product of genetics-environment interplay, where the client is produced as caught up in this gene-environment adversity, unable to regulate themselves or mentalise. This positioning may suggest a power differential where the 'expert' who is seen as 'safely attached', to use attachment terminology, and able to self-regulate and mentalise, as 'knowing' more about the client's subjective experience of affect regulation. This may contradict the clients' personal beliefs and experience of their predicament and how they can be helped, suggesting a power imbalance within the therapeutic interaction.

2.3.2 Cognitive Behavioural Perspectives of ASPD

Cognitive Behavioural Therapy (CBT) is one of the major approaches taught in Counselling Psychology trainings and practiced by CoPs (Woofle et al, 2010). CBT is also directly related to contemporary evidence-based research and practice, it is commonly used in the NHS and it is the main treatment recommendation for most mental health disorders by NICE guidelines. Thus, CBT is important to be considered in this research as it constitutes a main expert knowledge that influences contemporary understandings and therapeutic practices of ASPD.

CBT is currently a broad developing modality, initially originated to A.T. Beck's work in the 1960s and 1970s (Beck 1963; Beck et al, 1979). The 'Beckian' model of CBT has been dominant in the UK for the past 30 years and it is considered to be in the mainstream in this country (Westbrook et al, 2012). The core idea of CBT is that people's emotional reactions and behaviours are strongly influenced by their thoughts,

beliefs or interpretations about themselves and the world around them, and that behaviour is seen as crucial in maintaining or changing psychological states (Westbrook et al, 2012). In this context, psychological problems or difficulties are understood as resulting from problematic interactions between emotion/affect, cognitions, behaviour and physiology. To understand and explain behaviour, the actual beliefs held by a person must be explained (Millon et al, 2004). Beck et al (1990) distinguished three types of beliefs: *core* (non-conscious, absolute views of the self, world and future), *conditional* (if-then statements) and *instrumental* (what one *should* do) beliefs. The CBT view of therapeutic change lies in altering problematic thinking and behaving patterns, which then enables emotional and physical changes to occur (Westbrook et al, 2012; Bennet-Levey et al, 2004).

From a CBT perspective, individuals diagnosed with ASPD are described to have a cognitive style characterised by deviance, egocentricity and impulsivity (Millon et al, 2004). Higher goals and moral constraints are thought to be absent or vaguely developed and the antisocial mind is understood as invested in immediate gratifications and sensation-seeking behaviours (Meloy & Yakeley, 2013). Shapiro (1965) proposed that consciousness in ASPD consists of discontinuous series of fixation and frustrations that lead to a lack of insight, poor behavioural controls and self-indulgent, predatory actions. This thinking suggests that individuals labelled as ASPD, are either unable to create actions-consequences mental models or are highly vulnerable to the influence of immediate gratifications. Furthermore, from a Beckian perspective, *antisocials* seem to hold core beliefs that are organised around a need to see themselves as strong and independent (Beck & Freeman, 1990). The world is seen as a dangerous and hostile place that demands survival-oriented core beliefs, for example, "I must look out for myself" or "if I am not the aggressor then I will be the

victim” (Beck & Freeman, 1990: 5). Hence CBT thinking may suggest that these core beliefs reduce morality to ‘an eye for an eye’ situation where retaliation becomes a moral imperative (Millon, et al, 2004).

The founding premise for CBT interventions (Marlatt & Gordon, 1985) is that the targeted behaviour in this case ASPD is “learnt, motivated, and reinforced by internal factors within the patient and external factors within the environment” (Meloy & Yakeley, 2013: 16). For example, internal factors may include thoughts, feelings, beliefs, and fantasies, and external factors can be alcohol, stimulants, weapons (Hunter and Love 1993), or an available pool of victims (Meloy, 1988). Thus, CBT typically focuses on attempting to modify the impulsive, egocentric, illogical and rigid thinking of individuals diagnosed with ASPD (Beck & Freeman, 1990; Freeman & Leaf, 1989; Walters, 1990) as well as antisocial behaviours (Bandura, 1969). CBT is mostly provided in controlled environments such as correctional institutes and hospitals, as it has been suggested that successful treatment of ASPD can take place within settings where the individual’s resistance behaviour can be strictly controlled (Vaillant, 1975).

CBT is undoubtedly a dominant expert knowledge that informs contemporary psychological practices. Within a society where positive psychology thrives and the need for quick explanations and solutions to psychological problems and difficulties, CBT offers a ‘viable’ option for many: *change how you think, so that you can change how you feel and behave*. From a CBT perspective, the ASPD phenomenon is reduced to problematic cognitions and behaviours mainly located in the individual who is perceived as dysfunctional. Although, CBT is a wide spectrum with the more contemporary end (Third-Wave CBT models) being influenced by humanistic perspectives (for example Acceptance Commitment Therapy) or mindfulness practice (Mindfulness-based CBT), it remains highly influenced by the medical model where

categorical binaries (such as normal/abnormal) localise psychological disturbance within the individual.

Hence, it is argued that in a CBT treatment context of ASPD an 'expert' (Foucault, 1977) power dynamic may be mobilised, that enables practitioners to hold authority over the client's thinking and feeling subjective experiences through their CBT expertise. As such, clients may be positioned as unaware of their own thoughts and feelings and the therapist as the expert who 'knows better', what needs to be re-learned and modified. I suggest that this way of thinking about ASPD, not only reduces human experience and promotes a 'quick fix' but it also precludes the consideration of societal and cultural influences that may inform both psychological knowledge and practice.

2.3.3 The Biomedical Model of ASPD

Medical science and particularly neuroscience have become increasingly influential for various contemporary counselling and psychotherapy perspectives (Fuchs, 2004; Rizq, 2007; Cozolino, 2010). A biomedical approach to understanding personality disorders, and particularly ASPD, assumes that psychological experiences and problems have primarily an organic, biological base. The biomedical discourse of mental health, as discussed in the first section of this Chapter, stems back to ancient times and has formed a dominant expert regime that contributed to the medicalisation of human experience and suffering through time. Thereby, an exploration of such contributions is critical to be considered in this study.

Biomedical perspectives argue that individuals who fit in the diagnostic label of ASPD appear to have inborn temperaments such as toughness, fearlessness, impulsivity, aggression and sensation-seeking (Millon et al, 2004). It has been further suggested that *psychopaths*, in particular, suffer from an innate inability to understand and express meaning of emotional experience even though they have a normal understanding of language, a condition term as *semantic aphasia* by Cleckley (1941). More recent research on exploring discrepancies in the language of 'psychopaths' (Hare, 1993; Williamson et al, 1991; Louth et al, 1998) as well as cerebral blood flow studies (Intrator et al, 1997) have supported Cleckley's claims. Furthermore, some other biological traditions have argued that 'antisocials' have a great difficulty in physical arousal (Eysenck, 1964; Lykken, 1957), which is linked to their inability to appraise potentially dangerous situations.

Neurobiological models of ASPD have proposed that *antisociality* is linked with the function of brain systems (Cloninger, 1987b; Gray, 1987), whilst neurochemical findings attribute ASPD to hormonal imbalances. For example, low serotonin levels have been associated with aggression, violence and impulsivity (Siever & Trestman, 1993). Similarly, decreased levels of cortisol have been found in violent adult male offenders (Virkkunen, 1985). Additionally, it has been suggested that high levels of testosterone in the brain play an important role in aggression (Batrinos, 2012).

From a biomedical perspective, ASPD is constructed as a problem located in the body. This understanding not only privileges the idea that psychopathology has a biological base but also positions individuals who are diagnosed with ASPD as having *ill bodies* and/or *ill brains*, and in a sense as unable to escape their biological constraints. Furthermore, this thinking legitimises science, medicine and psychiatry as expert knowledges to have a central role in the management and treatment of those

labelled as ASPD. Perhaps an example of this legitimisation is the promotion of drug treatments that mainly target aggressive behaviour, hostility rates and cortical arousal (Markovitz, 2001; Sue et al, 1990) despite that “no biologic factor has yet been shown to be either a necessary or a sufficient cause of aggressive behaviour” (Berman et al, 1997: 311).

The influence of the biomedical discourse, and more specifically the psychiatric discourse, on contemporary psychological knowledge and practice is undeniable. This kind of discourse has infiltrated the psychological domain particularly through the use of diagnostic tools in mental health settings. The most widely used diagnostic tool in UK, the DSM-5 (APA, 2013), is located at the heart of the contemporary mental health system and contributes significantly to the construction of mental health disorders through the categorisation and classification of symptoms. The most recent edition, DSM-5 (APA, 2013) defines personality disorder as,

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (p. 645).

Specifically to ASPD, there is “a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood” (APA, 2013: 659)⁹. Hence from a DSM perspective, ASPD is defined in terms of standards of normality/abnormality producing as such binary understandings (‘either/or’). This perspective not only assumes that ASPD can be

⁹ See Appendix 1: DSM-5 Diagnostic Criteria for ASPD.

known empirically but also reduces significantly its complexity. These kinds of discourses have legitimised the development of positivist tools that can measure and thereby attempt to *prove* the scientific existence of certain antisocial characteristic. An example of this, is the PCL-R that was developed by Robert Hare (Hare et al, 1991; Hare 2003). PCL-R is highly influential and is widely used in mental health and prison settings to identify and measure psychopathic traits.

Finally, it is important to note that there are fundamental epistemological differences between the biomedical model and psychology, and more particularly Counselling Psychology, which is primarily embedded in humanistic values. Working with clients that are diagnosed with ASPD presents unavoidably a challenge for psychological practitioners as they are called upon to practice within competing ideological paradigms. Hence, psychological practitioners who draw upon the biological model or DSM understandings of ASPD may be subjected to essentialist and conformist views as well as be unknowingly confined within certain social, political or economic agendas.

2.3.4 Humanistic Perspectives of ASPD

Humanistic therapies are a wide term that includes a number of different approaches to therapy that have as a common denominator a deep desire to respect the other as a human, who is seen as able to self-actualise, exist and experience the world authentically (Bozarth, 1998; Scharf, 1996). Amongst the diverse humanistic approaches, Person-Centered Approach (PCA), which can be traced back to Carl R. Rogers' (1951; 1961; 1980) work, is the most influential and is widely taught in most UK Counselling Psychology trainings. Although it is acknowledged that the

contribution of other humanistic therapies is important, in this section I will mainly discuss and critique the PCA perspective on ASPD as the most relevant to the Counselling Psychology domain.

PCA takes a phenomenological approach to human experience and suggests that all humans have a unique capacity for reflective consciousness and a tendency for growth and self-actualisation (Rogers, 1951). From a PCA perspective, humans are seen as free, influenced by history and context but at the same time playing a role in who they are (McCulloch, 2012). The therapeutic relationship is understood as an integral component of person-centered therapy, with the therapist being driven by a deep respect for the client's subjective experience. The therapist strives to facilitate a therapeutic environment embedded in the core-conditions (empathy-unconditional positive regard-congruence) (Rogers, 1951), which are seen as central to enabling therapeutic change, whilst *listening*, reflecting and avoiding directiveness and interrogation (Bozarth, 1998; Kirschenbaum, 2003; Rogers, 1951).

PCA also inherits a critical stance towards labelling as well as assessment and diagnostic processes (Sanders, 2012; Wilkins, 2012) which are viewed as highly problematic (Warner, 2012). McCulloch (2012) writes,

From a PCA perspective, clients are accepted as individuals and diagnostic labels are not of psychotherapeutic concern. Rather, the unique understandings, experiences, desires and conceptualisations of clients are the focus in therapy sessions (p. 183).

Therefore, in a PCA context, the label of ASPD poses a number of problems as it does not account for individual differences, it may provide inaccurate and generic descriptions of human experience and hence dismiss such clients (McCulloch, 2012).

Although, PCA (and psychotherapy in general), has been discouraged from use in ASPD treatment (Ruegg et al, 1997; Seligman, 1990), PCA research is arguing otherwise. PCA studies have demonstrated that person-centered therapy can be particularly helpful for highly defensive resistant ASPD clients in comparison to directive interventions (Beutler et al, 1991; Greenberg et al, 2000) and that it can generate substantial desired changes in ASPD pathology (McCulloch, 2000).

There is no doubt that the PCA's objection to mainstream psychiatric discourses is highly important as it offers new ways of thinking about human suffering. Although PCA provides an alternative option to the dominant expert medical knowledges in terms of understanding human experience, psychopathology and therapeutic change, it does struggle to consider certain aspects of human subjectivity. For example, Richard Worsley (2012) a person-centered academic and practitioner, has suggested that PCA struggles in particular with the concept of 'evil', which has been historically attached to ASPD understanding. Thus, this may preclude more complex understandings of such experiences as well as it may foreclose their exploration within a PCA therapeutic context.

Furthermore, although PCA is in accordance with the humanistic value base of Counselling Psychology (Woolfe et al, 2010) it has often been criticised for its *simplistic* understanding of human psychopathology. Perhaps, its phenomenological emphasis may debar the therapeutic exploration of certain aspects of human experience as well as relational processes that may be taking place beneath conscious awareness. Additionally, its idealistic position in relation to the power relations between therapist and client (therapist-client are seen as *equal*) may obscure

complex power relations that may be implicated in the therapeutic relationship, including the humanistic one too.

2.3.5 Social Constructionist Perspectives of ASPD

Some contemporary psychological knowledges, that are located in the social-constructionist paradigm, have contested and critiqued modernist, essentialist models of *mental illness* and disorders (Berger & Luckman, 1966; Harper, 1995; Parker, 1999; Marecek & Hare-Mustin, 2009; Sloan, 2009) challenging the individualistic and asocial character of mainstream psychology and psychiatry. These approaches argue that knowledge, including psychological knowledge, is always shaped by its social and cultural context. In this view, language is seen as central to the constitution of knowledge as it shapes “what we know, what we see, as well as what we can say” (Marecek & Hare-Mustin, 2009: 76).

Social constructionist approaches, challenge the modernist notion that personality is a static formation of human traits (Powell, 1984; Burr, 1995; Fernando, 1995; Matthews, 1998). Rather, they understand personality as referring to

socially produced aspects of identity and affective experience that impede self-reflection, agency, autonomy, mutuality, participation, and other capacities that characterise meaningful living (Sloan, 2009: 68).

From this point of view, personality is constructed as something to be transcended. Therefore, personality disorder is not perceived as an enduring condition but as shaped by social and cultural influences (Burr, 1995) through interaction between the individual and the context (Powell, 1984).

Furthermore, it has been noted that the concept of personality reflects a *historical form of individuality* (Seve, 1978) associated with a particular order. Beck and Beck-Gernsheim (2002) suggested that there is a special form of regulation being established in society, where systematic problems are given less political responsibility and instead become more focused on personal failure. From this perspective, it could be argued that the use of personality disorder labels, such as ASPD, appoints responsibility for social problems onto individuals. Thus, social failures are 'rebranded' as personal failures to be treated, managed or regulated by those legitimised by society, in ASPD's case, by psychiatrists and psychologists.

A social constructionist view of personality disorder locates the responsibility for related antisocial behaviours outside of the human body and opposes the causation-objectivity approach and pathological focus of the medical model. Rather, responsibility is placed in the role of social and economic inequality and its contribution in the construction of *madness* and *badness*. Therefore, social constructionist thought challenges the power assigned to the disciplines of psychiatry and psychology in defining normality and abnormality, and thereby personality health or disorder, and their legitimacy in the regulation of human bodies and minds. This thinking aligns with Foucault's (1991b) theory of the progressive governmentalisation of the state, "moving from direct law enforcement towards indirect rule through inventing technologies for the regulation of conduct" (Quinney, 2011: 55).

Such a perspective, not only moves beyond the causation-objectivity-rationality modernist values in terms of understanding personality disorder, and more particularly ASPD, but also urges for issues of social inequality and injustice to be considered seriously by professionals. Mainstream psychiatric and psychological knowledges

pathologise the individual and undervalue the complex interplay between risk, need, illness and offending (Quinney, 2011), obscuring as such the contribution of social injustice in the phenomenon of ASPD.

Social-constructionist thought does offer an alternative to conceptualise ASPD moving beyond the individual realm and into the societal realm. From this perspective, perhaps a challenge that emerges in a clinical context is the diverse socio-cultural understandings that practitioners and clients may hold about mental *health* or *illness* and more particularly about ASPD. Taking into consideration the 'pre-assigned' power-laden positions to psychological practitioners and the clients in a therapeutic context, expert notions of *madness* and *badness* - even though resourced from a socio-cultural perspective - may have a significant impact on the person's subjective experience of being labelled as ASPD as well as the power games operating in psychological therapy. Hence, this study proposes that it is of critical importance to explore and interrogate psychological practitioner's and client's socio-cultural understandings of ASPD.

2.3.6 The emergence of *Dangerous and Severe Personality Disorder* in the UK

This brief section considers the emergence and importance of *Dangerous and Severe Personality Disorder* (DSPD) category as a contemporary construction of an extreme form of ASPD. DSPD was 'invented' by the UK government in 1999 as a response to intense press, public and political debates in relation to the high-profile case of Michael Stone. The DSPD program aimed to describe highly dangerous mentally disordered offenders that considered posing significant risks to themselves

and others and proposed how to detain and treat (Ascoli et al, 2011). This suggested that mentally disordered offenders were to receive special penal and treatment attention. The DSPD program is of high significance as it demonstrates how public, press and political views, beliefs in relation to mental health disorders as well as reactions to violent crimes related to mental health can affect public policy as well as treatment provision.

2.3.7 Summary of the pre-psychological and contemporary constructions of ASPD

In this genealogical and critical literature review, various historic ASPD constructions were explored. The first section of this chapter focused on pre-psychological concepts of ASPD from ancient times, through to the Middle Ages, the Enlightenment Era, the 19th and finally the 20th century with a particular interest in the historical and discursive development of the term ASPD and the early psychiatric influences on psychological knowledge. The second section, drew upon contemporary psychological knowledges (Psychodynamic, CBT, Humanistic), biomedical approaches and social constructionist perspectives of ASPD and highlighted the fluidity of these constructions as well as the power games implicated within the psychological practitioner-client interface.

Overall, it has been argued that ASPD is problematic and a hard to define concept; it is an opaque construct that carries social meaning. As demonstrated through this genealogical account ASPD has undergone a process of transmutation through time, where different disciplines, such as religion, medicine, psychiatry, psychology and sociology shaped contemporary understandings. Additionally, this

literature review has proposed that various theoretical understandings of ASPD may impact on how ASPD clients are viewed and treated. Thus, this study will adopt a critical perspective aiming to unmask any possible power relations implicated in expert ASPD 'truth claims' in the participants' accounts. The following chapter will introduce and discuss the method and methodology employed to conduct this research.

CHAPTER THREE

Methodology and Method

“People know what they do; frequently they know why they do what they do; but what they don't know is what they do does”

(Foucault, 1982: 187).

3.1 Introduction to Chapter Three

In this chapter, I present the post-structural methodology and the method that were employed to address the research question *“How do PPs construct ASPD and what are the discursive power relations, if any, in PPs’ therapeutic accounts regarding ASPD?”*. As argued in Chapter One, a discourse analytic approach influenced by poststructuralist epistemology and more specifically Foucauldian ideas was adopted. I initially introduce FDA and its epistemological framework in relation to psychological research. I then present the methodological design and the FDA analytic steps. Finally, I conclude with addressing the researcher’s reflexivity and the criteria for quality in qualitative research in relation to this proposed study.

3.2 Foucauldian Discourse Analysis in Psychology and its Epistemological foundation

In this subsection, I will initially discuss the poststructuralist epistemology that embeds this study. Additionally, I will further consider FDA in the context of Counselling Psychology and psychological research, and thus locate the proposed study epistemologically within the wider psychological research arena.

3.2.1 The Poststructuralist Epistemological Foundation.

Poststructuralism is an intellectual movement that was inspired by a group of mid-20th century French and continental philosophers and critical theorists. Poststructuralism came to prominence in 1960s -1970s (Merquoir, 1987; Poster, 1989) as an extension of Structuralism and challenged the prevalent modernist ideas, which undoubtedly shaped the mainstream psychological theories and practices at the time. It challenged the post-Enlightenment essentialist premise that truth lies out there awaiting to be discovered (Loewenthal & Snell, 2003) and thereby questioned the 'taken-for-granted' approach to the world and the notion that the explanation of social phenomena can be neutral (Gergen, 1985). Such approach postulates that "there can be no universal truths or absolute ethical positions [and hence] a belief in social scientific investigation as a detached, historical, utopian, truth seeking process becomes difficult to sustain" (Wetherall, 2001: 384).

More particularly, poststructuralist thought rejected the essentialist assumptions and proposed that reality is always mediated by language. In this context language is understood as "central to the way we view the world and is seen as constitutive rather than as merely descriptive" (Harper, 1995: 3) always fluid and flexible. In such epistemological positioning, knowledge is seen as historically and culturally specific, sustained in social processes (Harper, 1995; Burr, 2003). Hence, knowledge is "not something that a person has (or does not have), but as something that people do together" (Burr, 1995:8).

This study is located in a poststructuralist epistemology and therefore assumes that ASPD cannot be known empirically. Rather, it can be understood as a socially constructed concept that carries social meaning. It further assumes that knowledge is discursively generated and that there is not one objective 'truth' about ASPD and its

therapeutic applications. Thus, it is proposed that the analytic aim is to explore participants' ways of talking about ASPD, which constitute multiple therapeutic 'truths' in the domain of Counselling Psychology. Furthermore, it is suggested that the analytic inquiry of this study will focus on investigating what may be enabled or constrained through the various ASPD constructions as well as what it is produced as 'true' and whose interest different perspectives may serve.

3.2.2 A poststructuralist approach to Counselling Psychology and psychological research.

Foucauldian-influenced Discourse Analysis was initially introduced to Anglo-American Psychology in late 1970's and was taken up in UK under the name of post-structuralism (Arribas-Ayllon & Walkerdine, 2008). The poststructuralist ideas unsettled the mainstream positivism in the Psychology domain and offered new tools to explore the link between language, subjectivity and psychological research (Willig & Stainton-Rogers, 2001). This turn to language was marked by the highly influential publications of *Ideology and Consciousness* (Adlam et al, 1977) and *Changing the Subject: Psychology, Social Regulation and Subjectivity* (Henriques et al, 1984), which critically interrogated psychological theories and their role in constructing the objects and the subjects, which they study (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013).

Foucault's ideas on meanings and constitution of knowledge suggested that "psychology actively constitutes a social domain" (Arribas-Ayllon & Walkerdine, 2008:5) and influenced highly psychological research. Walkerdine (1984) applied poststructuralist ideas in developmental psychology and child-centred pedagogy, whilst Parker (1992; 1994: 1999b) used the same ideas to engage with Critical

Psychology. Furthermore, Rose (1979) drew from poststructuralist thought and developed his idea of the 'psy-complex' (Rose, 1985), which offered a meticulous critique of the psychological apparatus. Finally, Willig's (1998; 2008) work on discourse and health practices led to the development of a six stage FDA model, which informs the analysis of this study (see section 3.4).

From a psychological perspective, FDA is located in the Social Constructionism paradigm (Gergen, 1973; 1985) and more specifically, it is informed by a poststructuralist epistemology. In particular, the Foucauldian perspective that informed this study is positioned in the Discourse Analytic arena. Discourse Analysis (DA) is "an umbrella term for a number of different approaches to language" (Harper, 1995: 2) and it aims to provide insight to the functioning of bodies of knowledge and the power/knowledge nexus without claiming generalisability to other contexts (Cheek, 1997). In contrast to other DA analytic perspectives which adopt a 'bottom-up' approach (Potter & Wetherell, 1987) focusing on action orientation (Henriques et al, 1984) and on how language is used to manage stake in social interactions (Potter & Wetherell, 1995), FDA is a 'top-down' approach that focuses,

on issues of power, ideological practice and social process and typically draws upon analytical concepts of discursive regimes, interpretative repertoires, cultural narratives and subject positions to highlight the ways in which people are spoken through or by discourses (Edley & Wetherell, 1997: 205).

Thus, this study takes a 'top-down' Foucauldian approach taking into consideration the wider socio-political implications of talk and how people (in this

instance the participants) may become variously subjected to circulating discourses and discursive power relations (O'Callaghan, 2010).

Considering FDA as the chosen methodology for this study, it is important to acknowledge that although Foucault developed a methodological approach to research (archaeological and genealogical approaches), he did not *prescribe* a method for conducting discourse analysis. He was opposed to a *prescriptive* method (Graham, 2005) and stated, "I take care not to dictate how things should be" (Foucault, 1994: 288). Although Foucault has been fiercely criticised for not offering a concrete method (Harwood, 2000; Tamboukou, 1999) he did indeed remain committed to the postmodern ideological premise that there is not a universal truth to be discovered thus nor a certain method to go about unravelling the discovery of such 'truth'. However, some contemporary Foucauldian researchers have endeavoured to outline why FDA is of interest for psychologists (Arribas-Ayllon & Walkerdine, 2008) and have stipulated that FDA: a) begins with a historic inquiry of the topic studied (see Chapter Two), b) it moves towards the mechanisms of power that unravel between objects and subjects (see Chapter Four) and c) finally turns its focus to how subjects position themselves or are positioned in power relations (see Chapter Four).

In conclusion, FDA was chosen as the most appropriate method for this study because the analytic interest attends to unmasking the various objectifications of ASPD that are worked up in the participants' professional talk, the participants' positioning in relation to ASPD and its clinical applications and finally any possible discursive power games that may be implicated in participants' accounts. Hence, the analytic process will focus on what participant's 'real talk' does (Arribas-Ayllon & Walkerdine, 2008) and how the participants position themselves or are positioned in discursive power relations.

3.3 Methodological Design

In this section, the methodological design will be presented. The research proposal, ethics, pilot interviews, participants and data collection will be discussed. Also, the analytic steps adopted to produce the findings of this research will be outlined.

3.3.1 *Research Proposal and Ethics.*

The proposal for this research project was submitted on the 31st of March 2014 and was successfully approved on the 8th of April 2014 by the University of Roehampton's Psychology & Social Sciences Research Student Review Board (RSRB). After the successful approval of the research proposal this research project was submitted for ethical consideration under the reference PSYC 14/ 136 and was approved under the procedures of the University of Roehampton's Ethics Committee on 2nd of October 2014.

The conduct of this study abided by the British Psychological Society Code of Ethics and Conduct (BPS, 2009) as well as the University of Roehampton Code of Good Research Practice (University of Roehampton, 2010). In order to establish high standards of ethical practice the following issues were considered carefully and thoroughly:

- ***Confidentiality and Anonymity:*** Pseudonyms were used in the presentation of this analysis and all identifiable information were omitted. Participants were also advised to protect the confidentiality and anonymity of any client and organisational identifiable information.

- **Raw Data:** The audio-recordings and transcriptions were stored accordingly to the Data Protection Law and the files will be destroyed after 10 years as per requirements of BPS's guidelines for ethical conducting of research (BPS, 2009).
- **Informed Consent:** All participants signed a consent form (see Appendix 6), which informed them of their rights of confidentiality and freedom to withdraw from this research if they wished.
- **Debrief Process:** At the end of the interview participants were given a debrief form (see Appendix 7) to ensure the professionalism and the ethical conduct of the interview. The form provided the researcher's contact information as well as the professional contact details of the Director of Studies and the Head of Psychology at the University of Roehampton. No concerns have been reported.
- **ID Numbers:** ID numbers were given to all participants which were used to label the audio-recordings, transcriptions, electronic and hard files. The original consent forms, debrief forms and the list with the ID numbers were stored separately and securely to avoid any cross-identification.

3.3.2 Pilot Interviews.

After having obtained ethical approval for the conduct of this research, two pilot interviews were conducted to ensure that the research questions generated rich accounts in an ethical way. Feedback was obtained and discussed after each pilot interview. In both interviews, "How do you understand Antisocial Personality Disorder?" generated a valuable discussion around diagnosis and labelling and its links to clinical practice. Also, "how do you work therapeutically with individuals who

have been given the diagnosis of ASPD?” led to a rich discussion of the practitioner’s therapeutic role. The material that derived by the pilot interviews was used to form the final research questions.

3.3.3 Participants.

Recruitment of participants started in late October 2015 after the successful approval of the Ethics application. A number of organisations were approached using the Research Letter (see Appendix 3) and the Research Leaflet (see Appendix 4). However, the recruitment of participants via this route was not successful. In January 2015, I was invited to talk about my research project with the view of recruiting participants in a small conference for ASPD and also a Forensic Forum. Five research participants signed up as a result of both presentations. The remaining five participants were recruited through snowballing (see Appendix 8: Participant Flow Chart).

The inclusion criteria for participants were the following: participants had to be qualified and accredited psychological practitioners (Counselling or Clinical Psychologist or Psychotherapists) trained in the UK, with self-identified experience of working clinically with individuals who had an official diagnosis of ASPD. In the end, three Counselling Psychologists, four Clinical Psychologists and three Psychotherapists were recruited all trained at various UK training bodies. Although small studies employing FDA usually strive to recruit a homogenous group of participants, due to the dearth of CoPs working with ASPD, pragmatically I recruited other psychological practitioners.

At the interviews, participants were asked demographic questions related to their training and clinical experience (see Appendix 9: Demographics Table). This data

was considered in order to offer a context to the participants' accounts. Seven out of ten participants identified as integrative practitioners with emphases in various theoretical perspectives, whilst one of them mentioned that she was pursuing further psychodynamic training at the time of the interview. The remaining three participants identified as psychodynamic practitioners. All participants had clinical experience in NHS medium secure units and/or prison settings. Also, some participants had clinical experience working in community services, universities, corporate environments and private practice. The contextual influences seemed to be of significant analytic interest and they will be further discussed in Chapter Four and Chapter Five as appropriate. Finally, all participants expressed an interest in ASPD and its clinical applications and wanted to contribute to research. Possible implications of demographics of the participants are addressed in Chapter Four and Chapter Five as relevant.

3.3.4 Data Collection.

Semi-structured interviews were used to elicit the participants' accounts for this study. Semi-structured interviews are the main tool of data collection and data generation in discourse analysis (Potter & Wetherell, 1987; Willig, 2008; Willig, 2013). The purpose of this type of interview is to gain access to systems of beliefs, practices and constructs of knowledge in specific settings (Potter & Hepburn, 2005). According to the FDA guidelines described by Parker (1992) and Willig and Staninton-Rogers (2001), a sample size of ten participants it is appropriate and should generate sufficiently rich accounts in order to conduct the analysis.

Interviews varied from 45 to 90 minutes and were audio-recorded. Seven interviews took place at the location at the participant's place of work. The remaining

three interviews took place at a professional room arranged by the researcher. All interviews were transcribed by the researcher to ensure confidentiality. A copy of the interview transcription was sent to the relevant participant. None of the participants reported any concerns about the transcriptions.

The semi-structured interviews invited participants to talk about their understanding, knowledge and views of ASPD as well as how they worked therapeutically in their clinical practice with ASPD. Following the interview questions are listed:

- a. Could you tell how you have come to work in this specific clinical field?*
- b. How do you understand/ conceptualise ASPD?*
- c. How do you work therapeutically with ASPD?*
- d. Could you give me some specific examples?*
- e. What are your thoughts about the specific context you work in?*

Throughout the interviews, a number of client, organisational and team cases surfaced. All of those examples were explored ensuring confidentiality and anonymity. As a researcher, I endeavoured to remain close to the poststructuralist epistemology without directing the participants talk but at the same time it was of great significance to ask questions in an ethical manner to elicit participants' 'truth claims' and 'real talk'. During the interviews I pursued professionalism, curiosity and openness to facilitate the participants' sharing of their knowledge, understanding, practices and

experiences. No problems occurred during the interviews and none of the participants raised any concerns in relation to the conduct of the interviews.

3.4 The Analytic Steps

In this section I will describe the FDA analytic steps taken to carry out the analysis of the data. Firstly, I started the analytic process by engaging with the transcribed text (Arribas-Allyon & Walkerdine, 2008). Guided by the research question, I focused on how ASPD was ‘talked about’ or ‘worked up’ as a mental health construct. Secondly, in order to grasp the volume and the breadth of the data I created tables with the different themes that emerged for example, ASPD objectifications, challenges in clinical practice, clinical possibilities and contextual influences. Finally, Willig’s (2013) six-step guidelines were used as a framework to analyse my data. Willig’s six-stage FDA guide condensed successfully Parker’s (1992) 20 stages to six without compromising its analytic strength. More specifically these six steps included: discursive constructions, discourses, action orientation, subject positions, practice and subjectivity and aimed to a thorough and systematic approach to the data. Following these steps are presented in more detail.

- ***Step 1: Discursive Constructions***

Initially, the analytic process identified how ASPD was constructed as a discursive object. Explicit and implicit references to the discursive object were coded, which highlighted the subtleties of these constructions. A number of different objectifications of ASPD were identified that were relevant to psychological

knowledges and practices. For example, I noticed that many participants talked about ASPD as a problem located in the individual.

- ***Step 2: Discourses***

Following, the analysis progressed to focusing on how ASPD was constructed in multiple ways. Through investigating different ways in which ASPD was constructed it became possible to illustrate the different discourses on which the research participants drew upon to formulate ASPD as a recognisable (Butler, 1997a) “object of discourse” (Foucault, 1972: 50). Separate tables were created gathering the various constructions that seemed to substantiate the participants ‘truth claims’ in relation to ASPD. For example, some accounts objectified ASPD as a psychiatric construct while others challenged the opacity of the ASPD construct.

- ***Step 3: Action Orientation***

At this step, my focus shifted on interrogating ‘what’ was enabled or constrained when ASPD was constructed in specific ways in specific times in the text. For example, issues of defining ASPD, identifying challenges and possibilities in clinical practice as well as negotiating issues of power were highlighted.

- ***Step 4: Therapeutic Subject-Positions***

In step four, emphasis was given on the therapeutic subject-positions that were made available through the discursive resources. More specifically, I explored how the participants became variously subjected to different therapeutic subject-positions in relation to the construct of ASPD and how these positions seemed to enable or disable

ways of talking, feeling and relating to ASPD. For example, some participants talked about ASPD from a position of expert whilst others seemed to form resistances against expert knowledges.

- ***Step 5: Practice***

At this stage, the attention was directed to the relationship between discourse and practice and to what can or/and cannot be said from various subject positions. For example, I became particularly interested in what was enabled or constrained in ASPD therapeutic practice accounts.

- ***Step 6: Subjectivity***

This final step was concerned with the connection between discourse and subjectivity. The discourses, the relationship between ASPD objectifications and the therapeutic subject-positions were examined to highlight the potential implications for those involved. This final stage is highly speculative (Willig, 2013, Hanna, 2014) but it strives to identify “what can be felt, thought and experienced from within various subject positions” (Willig, 2008: 117).

In addressing the research question, I focused on the participants’ therapeutic subject-positions, including the discursive resources they drew upon to generate their ‘truth claims’ as well as the ways these positions were managed through their talk. By turning my focus on power relations operating in these participants’ talk and using more particularly Willig’s (2013) FDA guideline steps 4, 5 and 6 five distinct therapeutic subject-positions were identified, which will be discussed in Chapter Four. It is

suggested that the therapeutic subject-positions identified encompassed qualitative differences in terms of power relations implicated in therapeutic talk.

Upon identification of these therapeutic subject-positions, excerpts were selected to represent the talk from each therapeutic subject-position. All ten participants' accounts were analysed, but nine of those were considered and represented in the final write-up. It is acknowledged that some participants were represented more than others due to their rich and fluent accounts that captured certain ideas of interest more concisely and succinctly. As a researcher, I recognise that the analytic process is highly influenced by my own subjectivity as a psychotherapeutic counsellor and a trainee counselling psychologist. My thoughts and reflections on my own positioning are considered in the following section.

3.5 Researcher's Reflexivity

The acknowledgment of the researcher's influence on the research process "as a person (personal reflexivity) and as a theorist/thinker (epistemological reflexivity)" (Willig, 2013: 25) is central in the qualitative inquiry. Finlay and Gough (2003) underline the significance of exploring the influences that shape the generation of research accounts, while Fine (1992) stresses out the importance of "positioning the researchers as self-conscious, critical, and participatory analysts, engaged with but still distinct from our informants" (p. 220). Hence, in the process of dealing with the influence of assumptions, qualitative researchers attempt to approach their research practice reflexively (Morrow, 2005).

More specifically, from a poststructuralist epistemological perspective, the idea that the researcher can be disentangled and *set-apart* from the research through

reflexivity is questioned (Finlay & Gough, 2003). On the contrary, the identity of the researcher is seen to be ever fluctuating, multiple and incomplete (O'Callaghan, 2010). In Foucauldian terms, reflexivity can be understood as a surveillance practice (Foucault, 1977) through which subjects come to self-regulate towards standards and practices. Hence, in this epistemological context it is not only important to be reflexive but to be critical of one's reflexivity (Butler, 2005). Foucauldian critique as a virtue (Foucault, 1978b) is concerned with questioning one's reflexivity, one's subject-position in the research, one's attempt to challenge discursive norms and expose the limitations of the established order of things that subjects – including the researcher – are constituted (Butler, 2000). As a result, considering the poststructuralist view of reflexivity, I discuss some of the influences that motivated this study.

During my Diploma studies in Counselling and Psychotherapy I started working as a support worker in the homelessness sector with adults with a long history of offending and substance misuse. This was my first encounter with *antisocial presentations* in my capacity as a professional. In the first year of my PsychD Counselling Psychology studies, I was offered a job opportunity in an innovative housing project that aimed for the reduction of offending and the rehabilitation of offenders in one of the most deprived London areas. This professional experience gave me the chance to familiarise with the criminal justice system and work closely with forensic and psychology services in an effort to support my clients to 're-integrate' in the community. It was at this point that I was confronted with the official label of ASPD.

Working with individuals that had been extensively involved with forensic services and *fitted* the DSM description of ASPD, I became curious of how the notion of *antisociality* was understood as well as dealt with both by services providers and

service users. I found myself working in a context where different notions of *madness* and *badness*, such as ‘being antisocial’, ‘not conforming with social norms’, ‘being violent’, became part of my daily working routine. Observing as well as participating in the delivery of a service that aimed to decrease antisocial behaviours a number of questions were born: What was ASPD? What were we really trying to manage as a project? And, whose interest were we really serving? Although I never reached definite answers, these questions, brought me face to face with the complexity of the ASPD problem and the intricacy of the power dynamics implicated in services that are directly involved with the *management* of such *problem*.

Additionally, whilst I was conceptualising my research project I began working as a counselling assessor in one of the most deprived London boroughs. During this work experience I became interested in the impact of wider societal influences on therapy as a practice. I soon realised that the practice of therapy was mediated by the context it was provided in. Decisions about funding, management of services, actual delivery of therapeutic practices, promotion of certain therapy models in comparison to others, professional titles, issues around diagnosis and treatment contributed to the formation of a wider socio-political discursive arena within which therapeutic practices were performed. This experience forged further my curiosity about the influences of the *social* on the *psychological* and shaped greatly the motivations of this study.

Finally, during the course of this study, I became aware of my own limitations of understating ASPD. I came to recognise that I was positioned as *resistant* to this particular diagnosis, yet I had very little resources to understand ASPD other than the DSM-5 and the theories of psychopathology. While I was preparing this research proposal, I became acquainted with a whole new set of ideas embedded in social constructionism. During this phase as a developing researcher, my ideas and beliefs

about therapy as a practice were unsettled and I found myself having to navigate through multiple and often competing ideas about ASPD knowledges and practices; a process quite challenging yet incredibly enriching.

Concluding, in this study reflexivity is informed by poststructuralist thinking and aims to expose the limitations of the established order of things by which subjects, including the researcher, are constituted. Hence, the consideration of the influences discussed above are of great importance as they reveal the possibilities as well as limitations of my positioning as a researcher. A critique of my own reflexivity will be discussed in more detail in Chapter Five (see section 5.3.4).

3.6 Criteria for quality in qualitative research

Establishing criteria for the quality and the “goodness” (Morrow & Smith, 2000) of qualitative research has been a central inquiry for qualitative methodologists (Seale, 1999). A number of criteriologists (LeCompte & Goetz, 1982; Kirk & Miller, 1986; Altheide & Johnson, 1994; Guba & Lincoln, 1994; Patton, 2002) have endeavoured to set criteria for quality in qualitative research in different paradigms in an effort to improve qualitative research practice. In contrast to modernist approaches that focus more on the scientific terms of validity and reliability, as a way of testing the quality of quantitative research (Seale, 1999), qualitative approaches do not follow the classic scientific criteria as they are inspired by different ontological and epistemological assumptions. The Qualitative inquiry does not seek universal truths or objective, generalisable results but it is concerned with knowledge as context dependent (Hollway, 2007).

Adhering to the post-modern paradigm this study does not follow the classic scientific quality criteria (for example reliability and validity) that are applied in quantitative studies. From a poststructuralist angle the quality of research is concerned with “sensitivity to the context”, “rigour”, “coherence” (Yardley, 2000) and “authenticity” (Morrow, 2005). More specifically, FDA is not concerned with accuracy of the discourses as they are viewed as historically and socially bound. FDA does not assume that the researcher can be objective, but that he/she is interlinked closely with the research. The search for big truths claims becomes irrelevant and

the search for clarity and simplicity of meaning is seen as illusory because there will always be other perspectives from which to interpret the material under review. To seek a definitive account is, thus, a misguided undertaking (Humes & Bryce, 2003:180).

I suggest, that I have endeavoured to achieve this throughout this research process and account. Applying thoughtful and rigorous consideration for the subject studied (see Chapter One and Chapter Two) and following closely the epistemological ideas for the method of this study (see Chapter Four and Chapter Five) has been the main focus for me as a researcher throughout this study.

CHAPTER FOUR

Analysis

"[power is] never localised here or there, never in anybody's hands, never appropriated as commodity or a piece of wealth. Power is exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target: they are always also the elements of its articulation."

(Foucault, 1980: 98)

4.1 Introduction to Chapter Four

This chapter presents the results of the analysis which is offered as one reading of many possible and focuses on some of the ways these research participants, as psychological practitioners (PPs), construct and work therapeutically with Antisocial Personality Disorder (ASPD). It also addresses how they discursively position themselves or are positioned in particular power related regimes. As noted in Chapter Three 10 PPs were interviewed about their understanding, views and clinical experience with ASPD and five distinct therapeutic subject-positions were produced from these participants' accounts entitled as: "Dangerous to Know", "Damaged Goods", "The White Collar Psychopath", "Resisting to Psychiatric Norms" and "Critical Questioning", summarised in Table 1 below. These therapeutic subject-positions were defined by the ways these PPs 'talked' and produced 'truth claims' about ASPD and its clinical applications. The main analytic interest is on exploring the diverse power relations that were deployed in each distinct therapeutic subject-position. The first three therapeutic subject-positions focus on the diverse forms of compliance to extant expert knowledges (see section 4.2), whilst the latter two focus on the diverse forms of resistance practices to the extant expert knowledges (see section 4.3).

TABLE 1: Therapeutic subject-positions and their illustrative discourses

Therapeutic Subject-positions	Illustrative discourses of the therapeutic subject-positions
Diverse forms of compliance to extant expert knowledges	
“Dangerous to Know”	<ul style="list-style-type: none"> • “Dangerous to Know” resourced by a psychiatric discourse. • Accounts of dangerousness in clinical practice. • ‘Gatekeeping’: therapy as a social regulatory practice of “Dangerous to Know”.
“Damaged Goods”	<ul style="list-style-type: none"> • Accounts of “Damaged Goods” as other and damaged. • Accounts of clinical practice while working with “Damaged Goods”.
“The White Collar Psychopath”	<ul style="list-style-type: none"> • Accounts of “The White Collar Psychopath” as other and powerful. • “The White Collar Psychopath” in accounts of clinical practice.
Diverse forms of resistance practices to the extant expert knowledges	
“Resisting to Psychiatric Norms”	<ul style="list-style-type: none"> • Resistance accounts against the psychiatric norms. • Accounts of resistance through the employment of expertise. • Clinical practice accounts of active resistance against the ASPD diagnosis.
“Critical Questioning”	<ul style="list-style-type: none"> • “Critical Questioning” of notions of badness. • “Critical Questioning”: Who does more harm? • “Critical Questioning” of therapy norms. • “Critical Questioning” in clinical practice accounts.

4.2 Diverse forms of compliance to extant expert knowledges

This section will discuss the therapeutic subject-positions of “Dangerous to Know”, “Damaged Goods” and “The White Collar Psychopath”. The analytic account will focus on exploring how ASPD clients were discursively constructed as ‘other’ as well as the particular set of power relations implicated in each of these therapeutic subject-positions. Overall, the PPs who spoke from these therapeutic subject-positions seemed to variously produce themselves as ‘experts’, dominated by extant expert knowledges.

4.2.1 The therapeutic subject-position of “Dangerous to Know”

The first therapeutic subject-position identified in many of these PP’s accounts was entitled as “Dangerous to Know”. This position was resourced by a dominant psychiatric discourse and was mobilised by accounts that problematised ASPD as a phenomenon located within the individual who is labelled as such. In practice accounts, PPs positioned themselves as ‘experts’ and employed discourses of dangerousness and social regulation to talk about their clinical work with ASPD.

It is important to be mentioned that the participants who spoke from this therapeutic subject-position practiced in medium secure units. This particular context suggests that PPs practiced with individuals who have been deemed as ‘high risk’ and were managed and treated in a secure hospital environment. Thus, this contextual emphasis on risk management might have influenced the discursive production of this therapeutic subject-position.

TABLE 2: The therapeutic subject-position of “Dangerous to Know”

Therapeutic Subject-position	Illustrative discourses of this therapeutic subject-position
“Dangerous to Know”	<ul style="list-style-type: none"> • “Dangerous to Know” resourced by a psychiatric discourse. • Accounts of dangerousness in clinical practice. • ‘Gatekeeping’: therapy as a social regulatory practice of “Dangerous to Know”.

4.2.1.1: “Dangerous to Know” resourced by a psychiatric discourse.

This therapeutic subject-position seemed to produce singular accounts that objectified ASPD as a psychiatric construct.

Excerpt 1:

“...the idea of antisocial is that somebody breaks the rules [...] not conforming to social norms, having a sense of the fact that their way it is the right way and they’ll do things regardless and people are there to be used to achieve their one aim if you like [...] puts themselves first, struggles in relationships with the concept of another [...] thrill seeking, drug use, stealing, violence those sort of things” (Lisa 58-70).

Excerpt 2:

“For me it’s, erm, basically somebody has kinda of a real difficulty, [...] an inability to recognise societal kinda of standards for behaviour [...] they forever kinda of crossing boundaries [...] invading your space, erm, kinda of start to shut, [...] they have [...] problems [...] regulating their behaviour” (Nick 36-49).

Excerpt 3:

“...with Antisocial Personality Disorder, [...] there’s [...] impulsive behaviours such as criminal behaviours or drug taking and kind of just general impulsivity in their lives and, erm, difficulty kind of, erm, maintaining stability” (Samantha 67-71).

Excerpt 4:

“...sometimes is about getting one over other people [...] stealing from a shop is, or deceiving somebody is not just about being able to do those things, it’s, it’s about, it’s about the good feeling you get back from having deceived [...] somebody” (Nick 66-70).

In these extracts the behaviours identified as definitive of ASPD by these PPs seem to employ the categories provided by the DSM-5 (APA, 2013), the ‘psychiatric bible’ (Kutchins & Kirk, 1993). From a discursive perspective, it is interesting how these categories have become normalised in these participants’ vernacular talk, suggestive of how such expert knowledges infiltrate and work their power to label such clients as ‘other’ and dangerous. For example, the participants’ reference to the failure of conforming to social norms (Lisa, Excerpt 1/ Nick, Excerpt 2), impulsivity (Samantha, Excerpt 3: line 70), deceitfulness (Nick, Excerpt 4, lines 68-70), criminal behaviours (Samantha, Excerpt 3: lines 67-70/ Lisa, Excerpt 1: line 70) and violence (Lisa, Excerpt 1: line 70/ Nick, Excerpt 2: lines 46-47) demonstrates the unknowing influence of DSM-5¹⁰ discourse (see Chapter Two, section 2.3.3) on the ASPD construction produced by these participants.

Furthermore, this dangerousness seems to be located in the individual, which enables them to be produced as categorically ‘other’. For example, in Excerpt 1, Lisa’s reference to “breaking the rules” (line 58) and “not conforming to social norms” (line

¹⁰ See Appendix 1: Table 1, DSM-5 Diagnostic Criteria for ASPD

62) or Nick's highlighting their "inability to recognise social standards for behaviour" (line 39) illustrate this reductive binary construction of otherness as non-conformist. It is proposed that these participants' talk seems to privilege a narrowed and simplified version of ASPD, reducing it to a set of pathological behaviours. This understanding suggests a binary dividing practice (Foucault, 1982) separating ASPD clients as a distinct group, a specific discursive grid (Foucault, 1972), on the basis of specific actions and attitudes (Schirato et al, 2012). Hence, a categorical thinking seems to prevail, which generates a position of 'either/or', and more specifically 'good or bad', 'social or antisocial' locating the ASPD problem in the individual.

As Foucault (1972) writes the "psychiatric discourse finds a way of limiting its domain, of defining what it is talking about, of giving it the status of an object – and therefore of making it manifest, nameable, and describable" (p. 46). In identifying "who the problem group is and how the group is seen or known as a problem" (Scheurich, 1997:107), these participants seemed to distance themselves from ASPD clients through taking up the position of the 'expert' (Foucault, 1961) who holds uncontested 'truth claims' about ASPD. These PPs' accounts produced a deterministic view of ASPD clients "that overlooked individual uniqueness, consciousness and agency" (Sloan, 2009: 60) and at the same time underplayed the role of possible historical, social, economic and cultural influences that may contribute to a more critical understanding of APSD. Thus, this approach may limit alternative ways of conceptualising ASPD and exclude multiple diverse knowledges that could inform further PPs' understanding.

4.2.1.2: “Accounts of dangerousness in clinical practice.

Here, this therapeutic subject-position was evident in accounts referring to dangerousness of working with these individuals in the therapeutic relationship and therapeutic space. The illustrative discourse below is influenced by the specific context of medium secure units. The discourse produced by these PPs is resourced by their clinical experience with clients who are thought to be high risk towards others.

Excerpt 5:

“... there is always a threat there. You’re gonna get hurt emotionally or physically definitely” (Lisa 236-237).

Excerpt 6:

I: You spoke about this threat that may exist in the room while you are working with somebody.

P: Yeah. It’s a threat of violence. You know there is always a threat, [...] in the back of your mind. You do wonder if you are going to leave the room alive” (Lisa, 215-219).

Excerpt 7:

“...you try to be rational but you’re not engaging with a rational being [...] you’re always trying to think about ‘what am I saying, how can this be perceived, should I say it, should I not, why shouldn’t I say it’ and those sort of things, and you are just like, ok chair could be thrown at me” (Lisa, 258-262).

Excerpt 8:

“P: And it can be quite scary [...] you have to erm, erm have a double think about, erm, whether this person actually kinda of poses a, a risk to you [...] while you are in the room” (Nick, 327-334).

Above, participants’ talk mobilised singular accounts of dangerousness related to their clinical practice with ASPD. In these accounts, ASPD clients were glossed as

'risky in the room', violent, dangerous, irrational beings capable of causing grave emotional and physical harm. For example, in Excerpt 5, Lisa illustrates this position, by stating that "there is always a threat" that "you are gonna get hurt emotionally or physically definitely" (lines 236-237). Lisa further elaborates, in Excerpt 6, that this threat is a "threat of violence" (line 217) suggesting that clinical interactions with the ASPD subjects can be nothing else but dangerous and potentially fatal, as "you do wonder if you are going to leave the room alive" (lines 218-219). Similarly, Nick seems to take up the same position by describing his experience of working with ASPD clients as "scary" (Excerpt 8: line 327) that requires a particular 'expert' risk-thinking.

In producing such accounts, these PPs seemed to position themselves as vulnerable and deskilled, exposed to a pervasive ASPD threat of physical and emotional aggression in the clinical room. Ironically this subjectivity rather than sustaining the 'expert' role (Foucault, 1961) seems to be taking up a fearful position and thus distancing these PPs from their ASPD clients. This is further highlighted in Excerpt 7, where Lisa states that "you try to be rational but you're not engaging with a rational being" (line 258) producing herself as different and by inference a well-functioning practitioner who is vulnerable to the 'unpredictable' and 'unreasonable' ASPD clients.

While this understanding of ASPD may suggest clinical competence in identifying the potential risks involved in clinical practice, a competence that is highly recognised by clinical services, training bodies and the other relevant institutions, at the same time it may also promote a reductive and enfeebling construction of ASPD that locates practitioners in a de-skilled ideology of 'violence' and 'dangerousness'. It is proposed that such positioning produces discursively a particular form of 'otherness'

that may foreclose different possibilities of thinking, feeling and working with ASPD clients.

4.2.1.3: *'Gatekeeping': therapy as a social regulatory practice of "Dangerous to Know".*

Considering the ASPD construct as a discursive formation and the psychological practice as a system of formation of 'disorderly' objects (Graham, 2005) the illustrative discourse below, exemplifies how some PPs positioned themselves discursively in a social regulatory role of protecting the public.

Excerpt 9:

"...your role is to acclaim public protection" (Lisa, 570-571).

Excerpt 10:

"...you are a gatekeeper [...] the notion of risk is so difficult to hold in mind and risk and therapy don't always sit well together [...] in the crisis moment you don't know what a person is going to do. The reality is they've done it before." (Lisa 662-702).

Excerpt 11:

"...forensic psychotherapy that I was taught the point is to stop people offending [...] we are very clear about our intention [...] the patient gets to know himself or herself a little better, becomes more in touch with the why of the behaviours, in order to change behaviours, so it very much has a social agenda [...] a psychotherapist has to have some sense of social responsibility" (Jane 101-109).

In these accounts, participants inhabiting the therapeutic subject-position "Dangerous to Know" seemed to also locate themselves in a position of obligation to keeping safe the wider community. Here, the role of therapy appeared to be constituted as a social regulatory practice of safety assurance, where the practitioner

is produced as the 'gate-keeper' (Lisa, Excerpt 10: line 662) who has the responsibility to manage the 'disorderly' clients (Graham, 2005) and protect the public from them. For example, in Excerpt 9, Lisa states with certainty that the practitioner's role is "to acclaim public protection" (lines 570-571) emphasising "gatekeeping" (Lisa, Excerpt 10: line 662) as central to her therapeutic responsibility.

Similarly, Jane, in Excerpt 11, privileges the idea of the therapist as a 'gatekeeper', underlining that "the point is to stop people offending" (line 101). Jane further states that therapy "very much has a social agenda" (Excerpt 11: line 108) admitting in a sense to the wider socio-political influences on therapeutic practices. Although, Jane notices the power games that may be implicated in relation to ASPD she does not contest them, but rather she seems to accept this 'truth claim' by stating further that the practitioner "has to have some sense of social responsibility" (Excerpt 11: line 109).

Hence, it is suggested that these participants seemed to be dominated by the wider discourse of *madness* and *dangerousness* as forms of otherness and danger requiring regulation that was unmasked by Foucault (1961; 1988) through the interrogation of its management. This was illustrated in the genealogical review of ASPD in Chapter Two (see section 2.2.3).

Overall, in this illustrative discourse of "Dangerous to Know", PPs seemed to position themselves discursively as the 'good', socially responsible 'experts' whose job is to manage and police the 'bad' and 'dangerous' ASPD clients and therefore to protect the 'vulnerable' public. Such positioning seems to reduce therapy to a disciplinary regime that prioritises the confinement and regulation of populations, in this case the "Dangerous to Know", suggestive of a 'top-down' power differential

(Foucault, 1977). Therefore, therapy seems to be produced as a social regulatory practice invested in protecting public interests rather than focused on the therapeutic needs of ASPD populations. This unavoidably raises an important question: In whose interest is therapy being provided for? Thus, it is proposed that these PPs seem to be uncritically dominated by a wider socio-political agenda that prioritises the confinement and regulation of such clients.

To summarise, the therapeutic subject-position “Dangerous to Know” has been illustrated as resourced by a wider psychiatric discourse. ASPD clients were objectified as dangerous ‘others’, while PPs who spoke from this therapeutic subject-position took up a dominant expert position (Foucault, 1982). Interestingly, in clinical accounts of practice, PPs produced themselves as fearful and deskilled ‘experts’ in relation to ASPD clients. Finally, PPs privileged accounts of therapy as a social regulatory practice and seemed to be hegemonised by wider socio-political ‘truth games’ unable to critically contest the discursive resources they were subjected to.

Finally, it is important to mention, that the therapeutic subject-position of “Dangerous to Know” highlights issues of professional conflict and power. More specifically, the conflict between the ethical stance of counselling psychology and the social control facet is ‘evident’ particularly in the third illustrative discourse of this therapeutic subject-position. The ‘gatekeeping’ discourse produced by these PPs uncovers power-laden tension between competing ideologies that PPs are called upon to face in their clinical practice.

4.2.2 The therapeutic subject-position of “Damaged Goods”

The second subjectivity, in these participants’ accounts, was entitled as “Damaged Goods”. Contrary to the previous subject position, PPs who spoke from this subjectivity mobilised a different form of ‘otherness’ in constructing ASPD clients as damaged developmentally by the neglectful and abusive systems of family and society in general. Additionally, in clinical accounts of practice, these PPs produced themselves as ‘experts’ and resourced their expertise from various expert psychological knowledges when talking about their clinical work with “Damaged Goods”.

Table 3: Therapeutic subject-position of “Damaged Goods”

Therapeutic Subject-position	Illustrative Discourses of this therapeutic subject-position
“Damaged Goods”	<ul style="list-style-type: none">• Accounts of “Damaged Goods” as other and damaged.• Accounts of clinical practice while working with “Damaged Goods”.

4.2.2.1 Accounts of “Damaged Goods” as other and damaged.

In this illustrative discourse, these PPs produced accounts that objectified ASPD clients as damaged developmentally by systemic neglect and abuse. This is illustrated in the following extracts.

Excerpt 12:

“...you do get situations where you’ve got a mother who is not available or father who is violent, there is alcohol and drugs in the home, the child’s been brought into the world, is not particularly wanted, or left alone to its own devices, does not do particularly well at school, gets in trouble, gets involved in gangs because [...] parents are not that particularly concerned about them, may actually then be unpredictable in terms of beating them [...] so then they go down the routes of crime, things like that, violence aggression” (Lisa 386-394).

Excerpt 13:

“...they have biographies of terrible neglect and abuse that have not been addressed by social systems and not been picked up in education, welfare system, that the criminal population is largely made up [...] that society has cheated on some way, they didn’t have their ordinary human rights, if you think about why people become antisocial it starts with society and why we’ve excluded, neglected, [...] and abused them” (Jane, 132-139).

Excerpt 14:

“the majority of women who were in there, erm, if not all, had, I don’t think there was one, I can’t remember not working with a woman who hadn’t been, erm, physically and sexually abused at a very young age by a male” (Ellis, 180-182).

Excerpt 15:

“...I also think [...] how other people have kinda of treated you lends, lends towards you breaking kinda of the rules of society because, you know, society hasn’t kinda of treated you particularly well” (Nick, 108-111).

The professional talk produced by these PPs seems to fabricate a different kind of ‘otherness’. Here, ASPD clients are still constructed as ‘other’ and ‘different’, but this time as damaged rather than dangerous. In the excerpts illustrated above, ASPD clients are talked about as damaged victims of neglectful and abusive social systems

from childhood. For example, in Excerpt 12, Lisa produces a detailed account of how parental failure to provide a caring environment ‘damages’ such clients and “so then they go down the routes of crime, things like that, violence aggression” (lines 393-394). Furthermore, in Excerpt 13, Jane produces ASPD clients as damaged victims through “terrible neglect and abuse” (Excerpt 13: line 132), whilst Ellis, reaffirms the production of “Damaged Goods” by referring to his definite claim that all of the women he worked with have been “physically and sexually abused at a very young age by a male” (Excerpt 14: line 181-182).

Additionally, it is suggested, that these PPs privilege the idea of ASPD clients as irreparably damaged by family or societal structures, and in a sense suggesting implicitly that these systems are to blame rather than the individual. This is illustrated in Jane’s statement “that society has cheated on some way” (Excerpt 13: line 135), and Nick’s argument that these clients are “breaking kinda of the rules of society because, you know, society hasn’t kinda of treated you particularly well” (Excerpt 14: lines 110-111). This understanding seems to reduce the complexity of how systems interact with individuals and vice versa and how the effects of this interaction may contribute in shaping and forming personalities.

It is proposed, that these PPs seem to resource their understanding of ASPD from psychological developmental literature on trauma and its effects on personality development (see Chapter Two, section 2.3.1c). In privileging such perspective, these practitioners seem to position themselves as ‘experts’ (Foucault, 1961) and simultaneously produce ASPD clients as ‘done to’ and ‘damaged’, thereby as ‘other’. Such understanding may promote a simplistic view of ASPD clients who are objectified as passive recipients of the effects of developmental trauma, and hence release them from any responsibility for their actions and behaviours as adults.

4.2.2.2: Accounts of clinical practice while working with “Damaged Goods”.

Considering the objectification of “Damaged Goods” attention is turned to how the participants who spoke from this therapeutic subject-position talked about their clinical practice with such clients.

Excerpt 16:

“we were in a kind of primitive, erm, erotic transference [...] being enacted out [...] it was interesting to work through some of that with some of the women [...] who had been abused from very young age [...]and to be able to work with the more seductive qualities [...] not get into that kind of game play [...] unconscious game that was” (Ellis, 182-198).

Excerpt 17:

“I think that when the attachment system is activated or threatened I think that is when you get a lot of the defences, the impulses, the sort of antisocial behaviours emerge because they do not feel secure, they don’t feel safe, the world is dangerous, the world is threatening or they have to make themselves feel safe that is definitely, definitely what I’ve seen [...] when the attachment has been broken or for example in my clinical practice when people have gone breaks, [...] that’s when you see a lot of the more antisocial behaviours come out” (Lisa, 100-108).

Excerpt 18:

“...A year and a half ago, I had, erm, one of my most difficult, challenging clients after being qualified [...] He was treated incredibly poorly as a child, his mum a drug abusing, heroin using and, erm, erm, basically she didn’t look after him at all, was repeatedly found completely neglected by family members or friends [...] we were doing DBT at the time and we were making lots of links with how he was brought up as a child and how he felt invalidated, and the more he understood those links [...]

his anger lessened and his recourse to antisocial acts kind of lessened over, over the time [...] But he was incredibly damaged” (Nick, 123-172).

The professional talk exemplified in the extracts above, highlights how these PPs positioned themselves discursively as the ‘experts’ (Foucault, 1961), who seem to resource their clinical expertise from different psychological expert knowledges to talk about their clinical practice with “Damaged Goods”. For example, Ellis’ reference to “erotic transference [...] being enacted out” (Excerpt 16: lines 182-183) and “to be able to work with the more seductive qualities [...] not get into that kind of game play [...] unconscious game” (Excerpt 16: lines, 194-198) produces him as the psychodynamic expert who somehow is able to notice unconscious dynamics and, at the same time, positions these clients as unaware of the influence of the damage imposed to them through abuse (see Chapter Two 2.3.1a).

Similarly, Lisa, in Excerpt 17, resourcing herself from the attachment theory describes the idea of how “when the attachment system is activated or threatened [...] you get a lot of the defences, the impulses, the sort of antisocial behaviours” (lines 100-101) inferring as such to the existence of a ‘damaged’ attachment, referred to in the literature as ‘insecure’ attachment (see Chapter Two, 2.3.1c). Furthermore, Nick in Excerpt 17, referring to Dialectic Behavioural Therapy (DBT) as an expert knowledge uses the idea of making links with childhood as a way of working with his client who he refers to as being “incredibly damaged (Excerpt 17: line 172) (see Chapter Two 2.3.2).

Additionally, this kind of expert talk privileges the idea that the practitioner as the expert has some sort of superior knowledge over “Damaged Goods” creating a

particular kind of distance between the 'experts' and such clients. Hence, this positioning seems to legitimise the expert practitioner to make certain 'truth claims' upon "Damaged Goods" promoting a simplistic view of these clients and the nature of the therapeutic work. It is argued that a positioning as such, may foreclose a more pluralistic and reflexive stance in terms of the therapeutic applications of ASPD.

In summary, the participants who spoke from the therapeutic subject-position "Damaged Goods" produced another form of 'otherness' in relation to ASPD, that of being damaged victims. In clinical accounts of practice, these PPs seemed to position themselves as the 'experts' who hold expert knowledge of "Damaged Goods" and the therapeutic process. This positioning seemed to privilege a simplistic view of the clinical practice with "Damaged Goods" foreclosing possibly a more reflexive and pluralistic approach to ASPD and its clinical applications.

4.2.3 The therapeutic subject-position of “The White Collar Psychopath”

The third therapeutic subject-position was identified as “The White Collar Psychopath”. In this therapeutic subject-position, participants’ talk mobilised a distinct construction which seemed to capture a particular aspect of ASPD. It is important to mention that this therapeutic subject-position is particularly influenced by context as these PPs drew examples from private practice and corporate environments.

Table 4: The therapeutic subject-position of “The White Collar Psychopath”

Therapeutic Subject-position	Illustrative Discourses of this therapeutic subject-position
“The White Collar Psychopath”	<ul style="list-style-type: none">• Accounts of “The White Collar Psychopath” as other and powerful.• Accounts of clinical practice while working with “The White Collar Psychopath”.

4.2.3.1: “Accounts of “The White Collar Psychopath” as other and powerful.

From this therapeutic subject-position, the participants’ accounts produced the construct of “The White Collar Psychopath”. These participants spoke about this particular objectification as a distinct construction of ASPD.

Excerpt 19:

“...if you’re from more kind of privileged socioeconomic status and you have good education [...] your antisocial behaviours might come out in different ways that they don’t necessarily get you into contact with police or justice services. And the kind of the idea [...] the white collar psychopath [...] those antisocial behaviours may come out in business environments but in a way that does not necessarily attract, erm, the attention of the police and, or the attention of mental health services (Samantha, 98-105).

Excerpt 20:

“...if you happened to be, you know, reasonably well educated antisocial narcissistic personality disorder, you might well be the prime minister [...] I’d like to think that prime minister is one of those people [...] whereas if you’re less well educated or whatever it is, you might be east end mobster [...] mafia, gang leader” (Craig, 977-983).

Excerpt 21:

“I’ve met, I mean the standing joke, you know, is CEOs and people who run big companies have quite pronounced psychopathic tendencies [...] I think it’s probably, you’d might find more of that in the real world than you actually find in prison” (Jane, lines 380-382).

The participants who spoke from this therapeutic subject-position constructed discursively a new recognisable ‘disordered’ object (Butler, 1997a) that seemed to differ significantly to the objectifications discussed in previous therapeutic subject-positions. The clients identified as “The White Collar Psychopath” are still produced as ‘other’, but this time as privileged, domineering and powerful enabled in high status positions by the wider society through valuing and praising. This is evident in Excerpt 19, where Samantha, highlights that “...if you’re from more kind of privileged socioeconomic status and you have good education [...] your antisocial behaviours

might come out in different ways” (lines Samantha 98-99). Similarly, in Excerpt 20, Craig’s daring account further suggests that the ultimate manifestation of this objectification could be expressed in the face of the prime minister (lines 977-978), whilst Jane in Excerpt 21 endorses the “standing joke” that “CEOs and people who run big companies have quite pronounced psychopathic tendencies” (lines 380-381).

These PPs seemed to work up an expert position resourced by wider psychological knowledges that objectified “The White Collar Psychopath” as a particular ‘psychological species’ that operates in the higher socioeconomic levels of society, such as business and political environments. This idea of the “successful” psychopath (Babiak, 1995, 1996; Lilienfeld, 1998) who remains undetected from the mental health and criminal justice system (Lynam et al., 1999), evident in Excerpt 19 (Samantha, lines 103-105) and Excerpt 21 (Jane, lines 381-382) links back to the work of Cleckley (1941) on psychopathy as discussed in Chapter Two (see section 2.2.5).

By producing these expertise accounts, PPs seemed to take up an ‘otherness’ position by identifying and defining this particular discursive grid (Foucault, 1972). This ‘othering’ position seemed to implicate a particular set of power relations where PPs uncritically produced another clinical essentialist category to be aware of. Although these PPs spoke about how particular privileged contexts may influence the formation of subjects and consequently how they are seen, labelled, treated and valued, they did seem to reflect critically on the ‘truth games’ they became subjected to. On the contrary, they inherited rigid singular views of “The White Collar Psychopath” reducing the complexity of this construction and simultaneously valorising certain essentialist claims of what this client group ‘is’ or ‘is not’.

4.2.3.2: “The White Collar Psychopath” in accounts of clinical practice.

Considering further the “The White Collar Psychopath”, the focus shifts to practice accounts that were produced from participants who spoke from this therapeutic subject-position. These practice accounts are further illustrated in the excerpts below.

Excerpt 22:

“...I’ve had quite a few patients that have been immensely successful in the world. [...] They have a state of mind which is about [...] other people aren’t really people in their world, they’re objects to be used [...] I’ve worked with a quite few high profile, high power figures, celebrities, CEOs, bankers [...] they didn’t want kind of major personality change, they didn’t want an alteration in the way they thought, thought about things, they come with a particular agenda” (Jane, 396-404).

Excerpt 23:

“...when I worked more sort of like the corporate side [...] their way is the right way and they’re gonna make it known at any cost. So they are very, very driven, and I think these are the traits that society prizes, ambition and stuff like that. But you kind of feel there is no room for another point of view, and this is the way it is going to be done, and they are gonna talk over you, and they’re gonna make it done” (Lisa, 295-302).

Excerpt 24:

“...they need to possess your mind in a sense [...] they need to be in control of all the sessions [...] privately I had two or three experiences of this, where there’s clearly, erm, this kind of traumatising narcissistic presentation, where they, where they want to buy you as the buy the therapist [...] there’ll be a real need to, to book sessions in advance and, and pay for sessions in advance so that they feel they can own you in that time” (Ellis, 602-610).

In these extracts above, participants seem to resource their expert clinical knowledge from the psychoanalytic perspective and more particularly the object relational thinking. This discourse is reminiscent of the object relations expert knowledge, which was discussed in the literature review (see Chapter Two, section: 2.3.1b). This is demonstrated in Excerpt 22, where Jane refers to the idea of ‘objects’ (“other people aren’t really people in their world, they’re objects to be used”, lines 398-399) to highlight the particular psychoanalytic psychopathology of the “White Collar Psychopath”. She further valorises this point by arguing that these particular clients “come with a particular agenda” (Excerpt 22: line 404) and thus implying that perhaps she herself as a therapist has been used as an object by “The White Collar Psychopath” in therapeutic interactions.

Additionally, Lisa, in Excerpt 23, resourced by object relational thinking, deploys the idea of the therapist being ‘taken over’ by these clients who leave “no room for another point of view, and this is the way it is going to be done, and they are gonna talk over you, and they’re gonna make it done” (lines 300-302), constructing these clients as domineering ‘others’. Similarly, Ellis using the idea of the ‘traumatising narcissist’, also referred to in the psychoanalytic literature as ‘malignant narcissism’ (Kernberg, 1989) (see Chapter Two, section 2.3.1b), objectifies these clients as domineering ‘others’ exemplified in his statement “they need to possess your mind in a sense [...] they need to be in control of all the sessions”.

By privileging an object relational ‘expert’ understanding of “The White Collar Psychopath”, these PPs seemed to position themselves as an expert authority that produces uncontested ‘truth claims’ about such clients. They seemed to be unreflexively dominated by the psychoanalytic object relational discourse and to assert their expertise by making definite claims about the clients in discussion. This

therapeutic subject-positioning is suggestive of a 'top-down' power differential (Foucault, 1977) in the therapeutic relationship and may suggest an unequal power dynamic between the client and the therapist.

It is also proposed that the talk produced by these PPs further constructs a particular kind of distance between such clients and psychological practitioners. Here, "The White Collar Psychopath" is discursively produced as high powered and self-centred client that hegemonises the therapeutic encounter by imposing his/her own therapeutic desires and wants. It could be argued that these participants constructed themselves as passive practitioners described by inference as used and dominated by "The White Collar Psychopath". Hence, it is suggested that by taking up such positioning PPs seemed to abdicate their own influence on therapeutic encounters with these clients.

To recapitulate, in this therapeutic subject-position PPs identified and defined a particular form of ASPD, that of "The White Collar Psychopath". "The White Collar Psychopath" was objectified as a particular 'psychological species' enabled in high powered positions. In accounts of clinical practice, PPs resourced themselves from the object relational thinking and seemed to be positioned discursively as 'experts' dominated by "The White Collar Psychopath" in therapeutic encounters disowning in a sense their own influence in therapeutic encounters with such clients. This therapeutic subject-position is influenced by the specific context of private practice and corporate environments, which seems to highlight the particular set of power relations as discussed above.

4.3 Diverse forms of resistance practices to extant expert knowledges

The final two therapeutic subject-positions exemplify two distinct sets of power relations identified in Foucault's power as resistance in his middle and later work (see Chapter One: 1.4.2). As discussed in Chapter One, from a Foucauldian perspective, the capacity for resistance is an integral property of power relations (Schirato et al, 2012) (see Chapter One, section 1.4.2). In this analytic section two forms of Foucauldian resistance are discussed and demonstrated through the data. The resistance practice of 'tactical reversal' (Foucault, 1978; Thompson, 2003) (see Chapter One, section 1.4.2), is discussed in relation to the therapeutic subject-position of "Resisting to Psychiatric Norms" whilst the form of resistance as 'technology of the self' (Foucault, 1988) (see also Chapter One, section 1.4.2) will be employed to explore the fifth and final therapeutic subject-position "Critical Questioning".

4.3.1 The therapeutic subject-position of "Resisting to Psychiatric Norms"

The fourth therapeutic subject-position was entitled "Resisting to Psychiatric Norms". In contrast to the therapeutic subject-positions described in the analytic section 4a, here the ASPD construct was questioned and these PPs produced accounts of resistance opposing to this diagnostic category. Some of the participants who spoke from this therapeutic subject-position opposed themselves to the ambiguity of ASPD by valorising the construct of psychopathy, whilst one participant produced herself as defiant to the ASPD diagnosis in her clinical practice.

Furthermore, this therapeutic subject-position seems to highlight professional power and conflict issues. The participants who spoke from this therapeutic subject-position seem to implicitly oppose themselves to the hierarchical power dynamics that

circulate in medium secure unit contexts. In such contexts, the psychiatric power is located at the top of the clinical hierarchy and influences greatly clinical decisions. Thus, the PPs seem to discursively ‘fight against’ the oppressions of hierarchical power by employing their own psychological expertise.

Table 5: The therapeutic subject-positions of “Resisting to Psychiatric Norms”.

Therapeutic Subject-position	Illustrative Discourses of this therapeutic subject-position
“Resisting to Psychiatric Norms”	<ul style="list-style-type: none"> • Resistance accounts against the psychiatric norms. • Accounts of resistance through the employment of expertise. • Clinical practice accounts of ‘fighting back’ against the ASPD diagnosis.

4.3.1.1: Resistance accounts against the psychiatric norms.

In the illustrative discourse exemplified below, participants mobilised accounts of opposition towards hegemonic psychiatric knowledges of ASPD and the dominant diagnostic norms.

Excerpt 25:

“... It’s a category that even if you try to box it up [...] it’ll just escape [...] and bleed into other categories all of the time [...] Partly I think because, it’s such a lazy label” (Craig, 1108-1115).

Excerpt 26:

“...it’s a stupid diagnosis cause it doesn’t make any sense [...] it’s just nonsense” (Aga, 290-293).

Excerpt 27:

“...I don’t really think that ASPD exists” (Aga, 997).

Excerpt 28:

“How helpful is that disorder as a label? [...] it’s almost too inclusive” (Eddie, 189-191).

Excerpt 29:

“...ASPD is just applied very widely” (Nick, 467).

In the extracts above, PPs seemed to position themselves as defiant against the psychiatric norms, through ‘fighting back’ discursively against the ASPD diagnostic label. This form of resistance that PPs seemed to employ, exemplifies a reaction to top-down expert power, known in Foucauldian (1978) terms as ‘tactical reversal’ (Thompson, 2003). For example, in Excerpts 25, Craig seems to inherit a recalcitrant stance against the diagnostic regime. He opposes himself to the ASPD diagnostic label by stating that it is “such a lazy label” (Excerpt 18: line 1115). Similarly, in Excerpt 26, Aga produces herself as defiant against ASPD by expressing strongly that “...it’s a stupid diagnosis cause it doesn’t make any sense [...] it’s just nonsense” (lines 290-293) and by questioning its very existence, “...I don’t really think that ASPD exists”, (Excerpt 27: line 997). Furthermore, in Excerpts 28 and 29, Eddie and Nick respectively, challenge the vagueness, broadness and unhelpfulness of the ASPD diagnostic label.

Thus, the PPs who spoke from this therapeutic subject-position seemed to locate themselves in terms of power, as ‘fighting back’ against the ASPD label and thereby still caught in a ‘tactical reversal’ (Foucault, 1978; Thompson, 2003). By employing resistant and reactive accounts in relation to the psychiatric expertise of diagnostic labelling, these PPs were subjected to power games of domination. Although these participants, who resourced this defiant discourse, attempted to challenge the diagnosis, and therefore indirectly the dominant psychiatric regime, they seemed to engage in a ‘battle’ with diagnosis rather than reflect critically. Hence, it is argued that these PPs seemed to construct a position of ‘tactical reversal’ (Foucault, 1978; Thompson, 2003) instead of rising above.

4.3.1.2: Accounts of resistance through the employment of expertise.

The participants who deployed this “Resisting to Psychiatric Norms” therapeutic subject-position, offered an alternative option to construct of ASPD, that of psychopathy. This is exemplified in the extracts below.

Excerpt 30:

“...I actually I don’t have the same feeling about, erm, about psychopathy, [...] or psychopathic personality disorder. [...] And mainly it’s because, (cough), the assessment process [...] the PCL-R [...] the assessment process makes more sense [...] it captures something about the kind of superficial charm and the glib and grandiosity and, erm, kind of the ease of forming relationship to impress people and the need to control and dominate and actually, you, you could see, you could definitely, there is evidence for that, [...] when interacting with people and, erm, and it would be more, I think, useful clinical category” (Aga, 130-157).

Excerpt 31:

“...psychopathy to me seems a bit clearer in the kind of cold, callous, unemotional trait, its lack of empathy, erm, (.) and that’s kind of measurable and you could look at change from it, and somehow that’s become part of this Antisocial Personality Disorder and almost lost in, in it really” (Eddie, 174-177).

Excerpt 32:

“...I see Antisocial Personality Disorder (*smiles*), as having a certain degree of validity about it as applied to population of people with certain traits in, in common. [...] but I see psychopathy as having far more validity to it [...] for my chap who had Antisocial, Borderline and he was also kind of psychopathic, he was on Psychopathy Check(list), high on the Psychopathy Checklist, erm, even though (*laughter*), erm, he may not later on may not classify as kind of antisocial he will always classify as psychopathic” (Nick, 439-456)

Here, psychopathy was constructed by these PPs as more scientifically valid, hence in a sense more ‘truthful’, clinical category. Whilst in the previous illustrative discourse above PPs positioned themselves as defiant against the psychiatric regime, interestingly here they worked up a contradictory position by re-embracing psychiatric and psychological expert knowledges evident in their talk.

For example, in Excerpt 30, Aga using expert language seems to resource her knowledge from the work of Robert Hare, who has defined psychopathy as categorically separate to ASPD (Babiak & Hare, 2006) (see Chapter Two, 2.1.2). Aga’s talk valorises the Psychopathic Checklist-Revised (PCL-R) (Hare, 2003) (see Chapter Two, section 2.3.3) as an accurate scientific measure for assessing psychopathy (Excerpt 30: lines 139-140) and glorifies psychopathy as scientifically superior to ASPD (Excerpt 30: lines 153-157). Thus, she seems to accept uncritically the existence of psychopathy. Similarly, Excerpt 31, Eddie also using expert positivistic

language constructs psychopathy as a 'clearer' (line 174), more 'measurable' (line 175) clinical category, whilst, Nick, in Excerpt 32, describes psychopathy as a more 'valid' (line 441) clinical construct producing essentialist claims in relation to psychopathy.

These rigid claims about the existence of psychopathy and its scientific superiority in comparison to ASPD are further illustrated in Nick's client account (Excerpt 32). For example, in his client talk, Nick produces himself as an 'expert' (Foucault, 1961) who is legitimised to make expert truth claims about his client's predicament. It seems to me that Nick (Excerpt 32: lines 452-456) asserts his expert positioning by employing psychiatric language and describing his client in relation to diagnostic labels.

It is suggested that this kind of expert talk, forms a distinct contradictory set of power relations. Although the same participants further above produced themselves as defiant to ASPD label 'fighting back' the psychiatric regime, they now repositioned themselves discursively as 'experts' and re-embraced unknowingly the psychiatric regime through the use expert language. Hence, they seemed to produce discursively themselves as 'the expert' (Foucault, 1961) and asserted their expertise by producing uncontested scientific claims with regards to the existence and the validity of ASPD and psychopathy.

4.3.1.3: Clinical practice accounts of 'fighting back' against the ASPD diagnosis.

Considering the therapeutic subject-position of "Resisting to Psychiatric Norms" attention is drawn to how Aga talked about her practice in relation to 'fighting back' against the diagnostic norms. Aga mobilised an account of opposition against the

ASPD diagnosis by challenging openly the psychiatric regime in her clinical practice. While other participants had similar concerns Aga's account was chosen because it seemed to capture more succinctly this positioning.

Excerpt 33:

"...at the moment I work with this woman who's got diagnosis of Antisocial Personality Disorder, and I've been trying to fight this, I actually challenge this, [...] the psychiatrist [...] couldn't actually answer [...] why she had this diagnosis [...] if we were to give this woman a personality disorder diagnosis [...] then it probably will be borderline personality disorder, cause she's got history of self-harming, unstable attachments, [...] and the antisocial bit [...] she does have a history of violence of erm, but it's all in the services" (Aga, 221-233).

Excerpt 34:

"...as another person I think, it's just bullshit to treat someone like that and [...] to give them sort of 'well actually you are antisocial' [...] an ASPD diagnosis [...] it gives people almost like a licence, not to try, not to ask these questions, like 'why is somebody doing this?', because it's an easy answer 'they're doing this because they have an Antisocial Personality Disorder'" (Aga 328-344).

It is suggested that, in the Excerpt 33, Aga produced an account of active resistance in her role as a psychological practitioner, 'fighting-back' the domination of the psychiatric regulatory power. Aga provides a client example and questions openly the ASPD diagnosis by interrogating directly the expert psychiatrist. She states, "I actually challenge this, [...] the psychiatrist [...] couldn't actually answer [...] why she had this diagnosis" (lines 225-228). In taking up this positioning, Aga positions herself as recalcitrant against the psychiatric power. Aga further uses her own psychological 'expert' knowledge to challenge the diagnosis by justifying why other diagnostic labels would be more accurate hence more truthful (lines 228-233). By using psychiatric

language Aga seems to position herself as 'equal' to the psychiatric power, and at the same time, she 'fights back' the psychiatric regime.

Aga's account of resistance seems to further highlight issues of hierarchical power in the context of medium secure units. In this context psychiatrists are positioned at the top of the clinical power by being authorised to assign diagnostic labels as well as to finalise treatment decisions, whilst clinical or counselling psychologists are positioned hierarchically below psychiatrists in terms of clinical power and responsibility.

Furthermore, in Excerpt 33, Aga's client seems to be positioned as a victim of the psychiatric system whilst Aga seems to produce herself as the 'expert-rescuer' who is invested in salvaging the client from the system. This discourse seems to be reminiscent of the Foucauldian understanding of 'Salvation' (Foucault, 1982) which is "strongly informed by a binary logic, always referring to some kind of movement from a fallen, abject, ignorant or corrupted state (identified with sin, death, morality, despair, evil) to something finer and better (grace, ever-lasting life, certainty, goodness)" (Schirato et al, 2012: 26).

Finally, in Excerpt 34, Aga employs vernacular language, speaking "as another person" (line 328) rejecting the ASPD by stating "I think this is bullshit, because, it's just bullshit to treat someone like that and [...] to give them sort of 'well actually you are antisocial'" (line 328-330), hence taking up a position of defiance. Aga further proposes that labelling is employed as an easy solution to a complicated matter, as a convenient silencing to enquiring what is actually going on (lines 341-344). However, it is suggested that although Aga attempts to contest the power games implicated in psychiatric and psychological practices she remains caught up in a 'fighting-back' set

of power relations rather 'rising above' and critically reflecting on these power dynamics.

Overall, the participants speaking from the therapeutic subjection-position of "Resisting to Psychiatric Norms" seemed to be aware of the power games implicated within the diagnostic practices. However, their accounts seemed to be discursively resourced by the very expert psychiatric knowledge which they are opposed to. The use of 'expert' language and their proposition of psychopathy as a more valid clinical category in comparison to ASPD revealed their uncontested reductive 'truth claims'. Hence, although these PPs worked up a defiant position in relation to the dominant psychiatric discourse they seemed to revert to the psychiatric knowledge in order to justify their 'expert' claims. This positioning unravels a contradictory subject positioning of defiance and subjugation to the psychiatric regime.

4.3.2 The therapeutic subject-position of "Critical Questioning"

By contrast to "Resisting to Psychiatric Norms" as discussed above, the fifth and final therapeutic subject-position, entitled as "Critical Questioning", positioned participants as resisting by 'rising above' the ASPD label and thereby escaping the constraints of this diagnostic construction.

Table 6: The therapeutic subject-position of “Critical Questioning”.

Therapeutic Subject-position	Illustrative Discourses of this therapeutic subject position
“Critical Questioning”	<ul style="list-style-type: none"> • “Critical Questioning” of notions of badness. • “Critical Questioning”: Who does more harm? • “Critical Questioning” of therapy norms. • “Critical Questioning” in clinical practice accounts.

4.3.2.1: “Critical Questioning” of notions of badness.

In contrast to previous reductive constructions of ASPD in binary understandings, here PPs critically reflected on the complex contextual and societal influences on shaping notions of ‘goodness’ and ‘badness’ in relation to ASPD.

Excerpt 35:

“...violence and the kind of the behaviour has existed throughout history, people are not born good or are not born bad. They have a set of experiences which leads to behaviour, and if we can understand that, then we can understand actually that all of us are capable of doing good or doing bad” (Samantha, 591-594).

Excerpt 36:

“...particularly with ASPD when it’s so linked to antisocial behaviour is it just a way of labelling behaviour that we as a society might not like? And might not approve of and actually might find quite frustrating, [...] maybe it’s a way for us as a society to kind of almost split of this bad element and give it a label and then we’d quite like just to stick it in a jail somewhere and forget about it [...] it’s a way of labelling something and the giving us as a society or clinicians an opt out close, ‘yes but, it’s really hard to treat, so we, we won’t’” (Claire, lines 493-501).

In the illustrative extracts above, both participants who spoke from this therapeutic subject-position seem to take up a reflectively critical meta-stance by interrogating historical and societal influences on the construction of notions of 'badness' and 'dangerousness' in relation to ASPD. This kind of discourse seems to link back to historic social approaches to ASPD (Henderson, 1939) (see Chapter Two, section 2.2.5) as well as contemporary social constructionist thinking (see Chapter Two, section 2.3.5). For example, in Excerpt 35, Samantha produces herself as 'rising above' the essentialist binaries of good-bad by arguing that violence is a historically influenced concept (line 591-593). Samantha further challenges the 'othering' that occurs through labelling by asserting that "all of us are capable of doing good or doing bad" (lines 592-593). By including herself in that statement Samantha works up a critical reflexive position acknowledging the societal power games she is subjected to.

Similarly, in Excerpt 36, Claire contests the wider socio-political games with regards to ASPD. Claire attempts to 'rise above' these socio-political power games by unsettling ASPD essentialist truths. She asks, "is it just a way of labelling behaviour that we as a society might not like?" (lines 492-493) and further suggests that labelling provides a way out from the ASPD problem for society as a whole, including psychological practitioners. In embracing a critical positioning that escapes the oppression of diagnostic norms, Claire continues 'rising above' by questioning what interests sticking the "bad element" (line 497) "in a jail somewhere and forget about it" (line 497) serves.

Both participants who spoke from this therapeutic subject-position, mobilised critical and reflexive accounts and attempted to move beyond essentialist 'truth claims' in relation to ASPD. These PPs demonstrated the capacity to think differently (Foucault, 1984) and encouraged a reflective space where questioning and critiquing

mainstream ASPD norms was enabled. Furthermore, they attempted to challenge the wider ASPD ‘truths’ they have become subjected to and unsettle wider ‘truth game’s by disputing whose interests the process of identifying, labelling and confining ‘badness’ serves.

4.3.2.2: “Critical Questioning”: *Who does more harm?*

Following, the focus is turned to Craig’s account who reflected critically on the distinct construction of “The White Collar Psychopath”. This is exemplified in the illustrative extracts below.

Excerpt 37:

“...in society when we’re talking about psychiatric patients [...] of one sort or another or prisoners of one sort or another, when we talk about antisocial personality disorder, we don’t talk about bankers, politicians [...] gangsters of all other kinds, using the same descriptions, but I think that we could and perhaps that we should [...] So who does more damage to society? [...] bankers in Canary Wharf who ruin the lives of millions [...] or the burglar that climbs and steals my video camera, or something? In terms of where the real damage is done to society, erm, there are far more psychopaths in Canary Wharf than there are in psychiatric hospitals or prisons” (Craig, 42-53).

Excerpt 38:

“...some of the leaders and people that, you know, running the place, are probably more disturbed than the, you know, than some of the people in the hospitals. But they’ve got the social advantage, or the intelligence [...] whatever it is to not get caught” (Craig, 1015-1020).

Here, Craig mobilised a politically charged account, 'rising above' and reflecting critically on the construction of "The White Collar Psychopath" and thus challenging wider socio-political discourses of antisociality and dangerousness. More particularly, he seems to work up a positioning that questions the wider society's inability to 'talk' about "The White Collar Psychopath", who is personified by "bankers, politicians [...] gangsters of all other kinds" (Excerpt 37: line 45-47). In this critical inquiry, Craig uses 'we' to include himself and in a sense to admit that he himself is also subjected to the wider discourses that obscure critical reflection of the phenomenon in discussion.

Furthermore, Craig seemed to take up a 'political' stance by highlighting in his talk issues of social justice. Craig strongly urges that "we could and perhaps that we should" (Excerpt 37: line 48) to talk critically in relation to "The White Collar Psychopath". It is proposed that Craig questions the wider society that silences the questioning of high powered figures as potentially antisocial and thereby 'rises above' these power games. This positioning is highlighted further in Craig's questioning, "So who does more damage to society?" (Excerpt 37: line 50). Craig's attempt to critique mainstream societal views mobilising the idea that 'bad', 'dangerous' individuals are not necessarily those labelled as such or locked away in institutions (Excerpt 38: lines 1015-1016). Thus, it is suggested that Craig's account could be understood as an attempt to interrogate wider socio-political games that are implicated in constructing notions of dangerousness and 'antisociality'. Such positioning seems to liberate a critical voice that allows Craig to critique and 'rise above' the domination of such wider 'truth games'.

4.3.2.3: “Critical Questioning” of therapy norms.

The participants who spoke from the therapeutic subject-position “Critical Questioning” further resourced themselves from a social constructionist discourse (see Chapter Two 2.3.5) and proposed a ‘necessary’ expansion of therapy as a concept to consider the wider societal influences.

Excerpt 39:

“...it’s really unhelpful just to view it as a mental disorder because it’s so much a part of a cause and then an effect in society. Actually, there’s need to be a societal response, [...] there’s no point in just providing psychological therapy alone” (Claire, lines 524-526).

Excerpt 40:

“I just think for things to change there needs to be a different approach and that needs to include looking at, erm, a societal intervention” (Claire, lines 587-588).

Excerpt 41:

“...we need to kind of make wider changes in society if we want to kind of make leaps forward and I suppose reduce the violent acts” (Samantha, lines 594-595).

In this illustrative discourse of “Critical Questioning”, these PPs seemed to produce themselves as ‘suspicious’ in relation to how the ASPD problem is therapeutically ‘managed’. A distinct facet seems to be a discursive shift from focusing on the individual to the societal context. It is proposed that this discursive shift enables these participants’ to critically gaze the wider societal power games. For example, in Excerpt 39, Claire challenges normative understanding of ASPD and implicates in her talk society’s influence on the construction of ASPD (lines: 523-525). She further produces herself as reflectively critical by stating that “psychological therapy alone is

not enough” (lines: 526-527) and calling for a for “societal intervention” (Excerpt line 40: 588). Similarly, in Excerpt 41, Samantha seems to produce herself as a critical practitioner and she embraces this critical positioning by suggesting “wider changes in society if we want to kind of make leaps forward” (lines: 594-595).

These PPs seemed to form themselves by mobilising a critical perspective (Foucault, 1978b) that contests and challenges the extant therapeutic norms and practices, resourcing a critical gaze on the wider societal ‘truth games’ in relation to ASPD. By questioning the sufficiency of psychological therapy as a solution to the ASPD problem, and thus in a sense questioning their role as psychological practitioners, Samantha and Claire seem to be enabled to surmount the domination and oppression of wider ASPD therapeutic ‘truth games’.

4.3.2.4: *“Critical Questioning” in clinical practice accounts.*

In talking about clinical practice, the PPs speaking from the therapeutic subject-position “Critical Questioning” seemed to remove themselves from being fully subjugated by the oppression of the ASPD label in their therapeutic work. This is exemplified in the Excerpts below.

Excerpt 42:

‘I just work with the person really and I think you know all of us yeah look what the diagnosis is, and then look what offence they committed but I will work with whatever presents itself in, in the room [...] whether that’s acting out behaviours or somebody who is at a point of which, you know, maybe thinking of changing their lives [...] That’s what I go with, I am not rigid in terms of ‘right that’s the diagnosis, what’s the model I am going to apply to this person in this setting’ (Claire, 109-117).

Excerpt 43:

“actually what you’re working with it’s just a, an individual person who has a particular set of experiences, which’s led to a particular way of viewing the world [...] people get to big debates about are we treating mental illness or are we treating personality disorder? And really I would rather throw all that out of the window and have kind of a (laughter), a psychological formulation for each person, because you then don’t have to get into that argument about ‘oh which is the correct diagnosis?’ [...] None of them, none of them describe the person and how they, how they’re relating to you, one person with schizophrenia is not the same with the next person with schizophrenia and it’s the same with personality disorder” (Samantha, 523-535).

Here, in the Excerpt 42 above, Claire seems to take up a critical stance in relation to her own clinical practice with ASPD. Her talk emphasises working with “the person” (Excerpt 42: line 109) refuting as such the hegemony of the diagnostic practices. Whilst working with the person she is able to access her expert knowledge, (“I think you know all of us yeah look what the diagnosis is, and then look what offence they committed”, lines 109-110) without being hegemonised and oppressed by it (“I will work with whatever presents itself in, in the room”, lines 110-111). Claire seems to produce herself as a critical reflexive practitioner who is open to thinking about each client’s personal needs (lines 113-114) and to adapt her clinical practice accordingly.

Similarly, Samantha seems to also repudiate the hegemonic oppression of labelling in her practice. This is evident in Samantha’s statement “actually what you’re working with it’s just a, an individual person” (Excerpt 43, lines 523-524) enabling her to unsettle diagnostic power games. Furthermore, Samantha by employing the practice of “psychological formulation” (Excerpt 43, line 530) she seems to allow

herself to escape the oppression of diagnostic power games in her practice and to form herself as a reflectively critical practitioner.

It could be argued that these PPs produced themselves as self-crafted (Foucault, 1988) practitioners who demonstrated the ability to 'stand back' and question reflexively their own clinical practice. Hence, these PPs seem to form a resistance practice as 'technology of the self' (Foucault, 1988), whereby they come to engage in a relation to themselves as practitioners without devolving to a state of domination (Schirato et al, 2012). Finally, it is proposed that such positioning reveals the complex wider power games that may implicated in scientist-practitioner and reflective-practitioner models (Strawbridge & Woofle, 2010) as discussed in Chapter One (see subsection 1.3) in relation to psychological knowledge and practice.

To summarise, PPs who spoke from the therapeutic subject-position "Critical Questioning" seem to 'rise above' the oppression of the ASPD construct and its clinical applications. They seemed to contest essentialist ASPD claims and to be more aware of the multiple complexities of the ASPD phenomenon. Finally, it is suggested that in practice accounts, these PPs formed a resistance practice as 'technology of the self' (Foucault, 1988), promoting a critical and reflective gaze in relation to the power games implicated in psychological practice.

4.4 Summary of the Analysis Chapter

In this analysis, five therapeutic subject-positions were identified as indicating distinct sets of power relations in terms of what was worked up as ‘true’ about ASPD and its therapeutic applications in these participants’ accounts. Each therapeutic subject-position provided a unique perspective on ASPD in terms of theoretical understanding, ways of talking about clinical practice and reflexivity were evident.

In summary, the first three therapeutic subject-positions, “Dangerous to Know”, “Damaged Goods” and “The White Collar Psychopath” seemed to produce diverse forms of compliance to extant expert knowledges. Here, clients were constructed as ‘other’ (for example ‘other’ as dangerous/ ‘other’ as damaged’, ‘other’ as a successful psychopath), whilst the PPs who spoke from these therapeutic subject-positions, were positioned as ‘experts’. Contrary to the first three therapeutic subject-positions, the latter two therapeutic subject-positions of “Resisting to Psychiatric Norms” and “Critical Questioning” demonstrated how some PPs mobilised accounts of resistance to the extant expert knowledges. More specifically, the PPs who spoke from the “Resisting to Psychiatric Norms” produced themselves as defiantly reactant to ASPD as a clinical category and seemed to be caught up in Foucault’s view of resistant power as ‘tactical-reversal’. By contrast, the PPs who positioned themselves in “Critical Questioning” seemed to ‘rise above’ the constraints of the ASPD label and instead spoke from a meta-position, critically reflecting on some of the complexities of this phenomenon.

Overall after analysing critically these PPs’ accounts, I argue that ASPD is problematic as a clinical category. The analytic results highlighted the ways in which these participants produced multiple ‘truth claims’ about ASPD and its therapeutic applications, demonstrating a range of discursive power relations operating in these

PPs constructions. Thus, it is proposed that this critical analytic perspective may contribute to raising CoPs' (as well as other psychological practitioners) awareness with regards to the discursive power relations in their 'truth claims' and practices in relation to ASPD.

Finally, the importance of contextual influences has been highlighted in the analytic commentary as appropriate. The particular contexts of the medium secure units and also private practice were considered to inform the thinking and discursive positioning of the participants. These contextual influences will be further discussed in Chapter Five (see section 5.3.3).

CHAPTER FIVE

Discussion

5.1 Introduction to Chapter Five

This final chapter discusses the findings produced to answer the research question, *“How do psychological practitioners (PPs) construct ASPD and what are the discursive power relations, if any, in PPs therapeutic accounts regarding ASPD?”*. By applying a Foucauldian Discourse Analysis to ten Psychological Practitioners’ therapeutic accounts of ASPD, three main findings were highlighted. Firstly, as discussed in Chapter Two, ASPD understood through a genealogical lens seems to be constructed through time in diverse, opaque and often contradictory ways. This opacity of ASPD was further indicated in the analytic findings. Secondly, the ways in which ASPD was constructed by these participants seemed to have implications for discursive power relations (Foucault, 1982). Lastly, the PPs’ ways of talking about ASPD were seen to produce five therapeutic subject-positions with distinct sets of power relations, which seemed to have implications for PPs subjectivity (Foucault, 1982; Butler, 2005).

It is important to acknowledge that this research adopts and maintains a poststructuralist epistemology. Therefore, no actual, generic material ‘truth claims’ can be made regarding causal influences of these diverse therapeutic subject-positions identified. The main contribution of this research is concerned with raising the readers’ awareness in relation to the power games implicated in these diverse therapeutic accounts of ASPD by the rhetorical power of argument and the illustrative PPs’ quotes (O’Callaghan, 2010) presented in Chapter Four.

In this final chapter, I will firstly discuss the possible contribution of the findings for Counselling Psychology. Secondly, I will evaluate the methodological limitations of FDA as well as the method, data collection and participants who took part in this study. In conclusion, I will present some suggestions for future research, explore my researcher's reflexivity as a researcher and offer some final thoughts in relation to this research.

5.2 The research findings and the possible contribution to Counselling Psychology

The main contribution of this thesis is that it offers to CoPs and other psychological practitioners a reflexive gaze (Finlay & Gough, 2003) by which to interrogate the discursive power games implication in their professional knowledges and 'truth claims' about ASPD. Furthermore, it highlights the discursive power games implicated in these diverse therapeutic accounts, and thus cautions practitioners to become more critically reflexive about the power relations in which they may be positioned discursively (Foucault, 1982; Butler, 2005). Therefore, this thesis urges the readers to *think* and *think differently* about how they negotiate their professional knowledges and practices within contemporary mental health contexts.

To begin with, it is proposed that the findings of this study highlighted the opacity of ASPD as a clinical category and by doing so it illustrated some problematic uses of language as a discourse in relation to ASPD. The analytic account explored the diverse ways in which the participants constructed and objectified ASPD demonstrating that the ASPD phenomenon is multiple and mutable in meaning. Hence, the findings of this study challenge essentialist claim in relation to ASPD and

propose that ASPD is not a scientific phenomenon that can be known empirically but rather a construct that is influenced and shaped by social processes.

Furthermore, the analysis paid particular attention to the power relations that the participants became intertwined with knowingly or unknowingly. After critically analysing the participants' accounts, five therapeutic subject-positions were identified and were illustrated in this thesis, highlighting some spaces that these PPs seemed to inhabit and vacate in relation to the ASPD as a discursive object. The therapeutic subject-positions identified were the following: "Dangerous to Know", "Damaged Goods", "The White Collar Psychopath", "Resisting to Psychiatric Norms" and "Critical Questioning".

It is suggested that the therapeutic subject-positions of "Dangerous to Know", "Damaged Goods", "Resisting to Psychiatric Norms" and "Critical Questioning" could potentially be considered and deployed in other professional contexts when examining for example various diagnostic labels. Thus, these identified subject-positions could perhaps offer a way of interrogating how professionals position themselves when having to negotiate multiple knowledges in relation to diagnostic labels. Additionally, it is important to acknowledge that the therapeutic-subject position of "The White Collar Psychopath" and its distinct set of power relations identified is particular to the ASPD construct and also a unique contribution of this study. The construction of "The White Collar Psychopath" as a 'domineering other' authorised the PPs who spoke from this therapeutic subject-position to produce themselves as the 'expert' who was 'done to' and 'used' by such clients. This positioning seemed to abdicate PPs' own influence and responsibility on the therapeutic encounter with these clients. This finding urges for raising awareness and critical thinking in terms of how such positioning may foreclose therapeutic possibilities with these clients.

More specifically, considering the first three therapeutic subject-positions, “Dangerous to Know”, “Damaged Goods” and “The White Collar Psychopath”, the participants who spoke from these therapeutic subject-positions seemed to produce diverse forms of compliance to extant expert knowledges. These participants seemed to construct ASPD clients as ‘dangerous other’, ‘damaged other’ and ‘domineering other’ respectively and, at the same time, they distanced themselves from such clients as ‘experts’. By taking up such positioning, these PPs seem to comply unknowingly with various extant expert knowledges and thus to get caught up in a ‘technology of domination’ (Foucault, 1977).

Furthermore, in the final two therapeutic subject-positions these PPs seemed to mobilise various ‘resistances’ in their accounts (Foucault, 1977; 1988). Two forms of resistance to the extant expert knowledges were identified: ‘tactical reversal’ (Foucault, 1977) and ‘technology of the self’ (Foucault, 1988). More specifically, the participants who spoke from the therapeutic subject-position “Resisting to Psychiatric Norms” were seen to employ a ‘tactical resistance’ (Foucault, 1977, Thompson, 2003) by relating to ASPD in an adversarial way and by ‘fighting against’ the psychiatric regime. In contrast, the participants who spoke from the therapeutic subject-position of “Critical Questioning” seemed to utilise a type of a resistance that enabled them to avoid engaging with an antagonistic relationship to prevalent diagnostic norms. They rather produced themselves discursively as critical, reflexive and self-crafted practitioners, exemplifying Foucault’s (1988) ‘technology of the self’. These PPs seemed to avoid the subjection to rigid and singular accounts of ASPD and its therapeutic applications and enabled themselves to speak critically with the intention to move beyond the therapeutic norms.

Finally, these therapeutic subject-positions are not understood as rigid and essentialist, but rather as ever-changing and ever-fluctuating. Foucault (1982) suggested that subjectivity is not fixed, but it is mutable, positioning and re-positioning constantly in talk. As such, the therapeutic subject-positions illustrated in the analysis are understood as diverse ways by which the participants can be located variously by discourse. The analytic data reflected this fluctuation and indicated how PPs positioned themselves discursively and moved between therapeutic subject-positions. Most participants spoke at least from two therapeutic subject-positions and therefore were seen to occupy different positions at different times.

overall, by identifying these therapeutic subject-positions and their distinct sets of power relations, this study encourages practitioners to become more aware of what is made visible or obscured by such 'truth claims' providing the means through which the participants' talk can be interrogated. Such a critique (Foucault, 1978b) promotes a critical questioning and enables reflexive thinking in relation to one's 'truth claims' about therapeutic practice by raising awareness of the power games implicated.

5.3 Evaluation of this study

This section, evaluates the FDA methodology and its potential limitations to addressing the research question. Any methodology chosen by any research creates the parameters of what it is made visible with regards to the specific subject studied. Hence, the discourse produced by employing FDA in this study could be considered a limiting discourse in itself. Following this, I will provide a critique of the FDA methodology, the relevance of this study, the method of data collection and finally the researcher's reflexivity.

5.3.1 A critique of Foucauldian Discourse Analysis

Foucauldian Discourse Analysis has been questioned by some for its very methodological existence (Arribas-Ayllon & Walkerdine, 2008). More specifically, FDA has been critiqued fiercely for the reluctance to delineate a research method, particularly with respect to Genealogy (Wetherell, 1998; Graham, 2005; Harwood, 2000). Foucault (1994) himself stated “I take care not to dictate how things should be” (p. 288) and wrote provocatively to challenge certainty, so that “all those who speak for others or to others” (Foucault, 1994: 288) no longer know what to do (Graham, 2005). As Harwood (2000) writes “if Foucault had prescribed specific methodology, he would have fallen foul of his own critique of truth and science” (p. 42). Thus, an awkward Foucauldian predicament arises: declaring a method poses a ‘danger’ of becoming prescriptive and essentialist or not doing so may trigger accusations of unsystematic speculation and lack of rigor (Graham 2005).

Considering this criticism of FDA with regards to the lack of clear guidelines for a methodological framework, it is important to acknowledge how this study has dealt with this methodological challenge. There is no doubt that this dilemma becomes a precarious scenario of “damned if you do, damned if you don’t” (Graham, 2005: 5). However, Willig (2008) suggests that this methodological flexibility enables space for the subject in question, its complexities and the analysis to emerge. Bearing this in mind, this study employed Willig’s (2013) six-step guidance (see Chapter Three, 3.4) to the support the analytic process, which felt appropriate but not constraining.

Furthermore, FDA has been criticised for its failure to acknowledge the reality of existence (Hanna, 2014). The suggestion that truth is seen as “always contingent or relative to some discursive and cultural frame of reference” (Wetherall, 2001: 393)

positions the non-discursive as subordinate. Thus, one possible FDA limitation is its inability to identify power dynamics that might unfold in non-discursive experience (Willig, 2013). Whilst this study can comment on the participants' accounts, no general or essentialist claims can be made with regards to how the identified discourses may affect therapeutic practice. As it has been argued throughout, this thesis does not embrace a positivistic stance, hence has no intention in reaching an objective absolute 'truth' (Arribas-Ayllon & Walkerdine, 2008). Instead, the analytic focus is on the social production of knowledge, particularly in relation to ASPD.

In addition, some contemporary theorists have argued that FDA is theoretically rich but data thin (Dickerson, 2012). However, I suggest that this study generated a large and rich quantity of data through the interviews and the analytic process, yet a small number of extracts have been chosen to succinctly substantiate an argument. Perhaps selecting different extracts would have inevitably led to a different argument. Nonetheless, it is up to the reader to decide whether the suggested presentation substantiates a compelling argument or has rhetorical power (Willig, 2013).

Moreover, FDA has been accused of offering only a nihilistic understanding of the subject (Hanna, 2014), which is seen as passive and controlled by the power/knowledge nexus. Thus, people

are not free agents who make their own meanings and control their lives;
rather, they have their lives, thoughts and activities 'scripted' for them by
social forces and institutions (Schirato et al, 2000: 117).

Although, one might argue, that there is an implied criticism of the participants as not being actively aware of the therapeutic subject-positions they occupy, my

intention was not to undermine the participants' knowledge and experience. Nonetheless, this study maintaining a poststructuralist epistemology influenced by Foucault, suggests that the participants as well as the researcher (see section 5.3.4), are unavoidably influenced by wider circulating discourses by which they resource their knowledge. Hence, the analytic motivation is concerned with shedding light on what is enabled or constrained through talk and its effects on how speaking subjects position themselves or are positioned discursively.

A final criticism of FDA comes from psychoanalytic thinking particularly about its conception of subjectivity. Some psychoanalytic thinkers challenge FDA for offering a 'thin' description of subjectivity and for assuming that discourse is at the heart of self-formation processes (Hollway, 1989), which may limit the possibility to consider self-formation as constructed around emotional investment and attachment (Willig, 2001). Hence this perspective suggests that subject positions are understood as constructed as personal investment or motivation (Hollway, 1989) rather than related to knowledge and power (Willig, 2001). However, it is acknowledged that such an exploration was beyond the remit of this particular analytic methodology.

5.3.2 The relevance of this study to Counselling Psychology

Whilst there is arguably a diversity of theoretical, psychological, psychiatric and psychological writings and studies on ASPD, there has not been a specific study interrogating how psychological practitioners position themselves or are positioned discursively in relation to these various discourses. Hence, this study is highly relevant to Counselling Psychology as it sheds light on the multiple constructions of ASPD and the discursive power relations implicated in professional therapeutic accounts. More

particularly, the literature review (see Chapter Two) revealed the multiple theoretical understandings of ASPD highlighting the competing ideologies that shaped contemporary ASPD knowledges and psychological practices. The influence of these competing ideologies on psychological knowledge production was further evident in the identified therapeutic subject-positions (see Chapter Four), where the participants were seen to negotiate variable ASPD understandings which seemed to have some implications for their clinical practice.

Furthermore, the movement to include Critical Psychology and Social Injustice issues in contemporary Counselling Psychology programmes has been a central development of the profession. This study embraces this movement and merits the cultivation of a critical and reflexive space where multiple perspectives are welcomed and considered. This is highly relevant not only to the ASPD construct but also any diagnostic category and their related therapeutic practices. It is suggested that applying widely this critical Foucauldian gaze in the Counselling Psychology domain, may benefit CoPs who are expected to navigate multiple and often competing knowledges, ideologies and practices (Woolfe et al, 2010). Thus, this study suggests that encouraging critical reflexivity in Counselling Psychology may offer the opportunity to consider alternative ways of thinking about psychological theories and practices and invite practitioners to think again and think differently about their knowledge and clinical practice (Foucault, 1988).

5.3.3 A critical evaluation of the method of the data collection

This study recruited ten Psychological Practitioners (PPs) in order to collect sufficient data for the analytic purposes. Recruiting participants and generating data via opportunistic sampling could pose a number of limitations for research. It is acknowledged that the findings of this study represent only ten PPs who chose to participate and offer their individual contributions. Inevitably, a different sample may have produced different accounts. Additionally, different methods of collecting data have their advantages and disadvantages. This study, in employing a post-structuralist stance, suggests that any talk can potentially offer an analytic contribution. Thus, the analysis would be different each time as it is seen as a co-created dialogue between the interviewer and the participant (Willig & Stainton-Rogers, 2001).

Although small studies such as this attempt to recruit a homogeneous group of participants, due to the dearth of CoPs working with ASPD, pragmatically I recruited other psychological practitioners (see also Chapter Three, section 3.3.3). Therefore, a more heterogeneous volunteer group of ten PPs was recruited. The demographics of the participants were introduced in Chapter Three (see Chapter Three, section 3.3.3), were presented in a table in the appendix (see Appendix 8) and will be further discussed here. It is important to acknowledge that due to the poststructuralist position taken up by this study the demographic categories are not seen as prescriptive. Whilst demographic categories may influence what is made discursively available for particular participants in particular times and contexts, they are still understood as social constructs that are inherently changeable.

The participant sample was diverse in terms of age, gender, ethnicity, training, and clinical experience. Six out of ten participants were women and four were men.

Although the gender categories were considered they were not addressed in the analysis as gender did not seem to influence participants' positioning. Female and male participants spoke variously from the all five therapeutic-subject positions. I would suggest that perhaps further research would be useful in exploring more systematically the issue of gender in therapeutic accounts of ASPD.

Seven out of ten participants identified as white British, one as black British Caribbean, one as white Eastern European with a Polish decent, and one as white Irish. Participants' ethnicity and nationality did not seem to be relevant to the analysis. Interestingly, race in relation to ASPD was only briefly discussed by Aga during her interview, but this account was not included in the analytic findings as there was not enough data.

Additionally, the research participants have been trained and have been qualified at least at a master level in UK institutions. Three out of ten participants were qualified as Counselling Psychologists, four out of ten were qualified as Clinical Psychologists and the remaining three as psychotherapists. Seven of these participants identified as integrative practitioners drawing mainly from psychodynamic, CBT and humanistic perspectives in their practice whilst the remaining three, all psychotherapists, identified as psychodynamic practitioners. Lisa and Nick who mainly spoke from the therapeutic subject-position "Dangerous to Know" and "Damaged Goods" were trained as Clinical Psychologists. Perhaps this is somewhat suggestive of the influence of different trainings of ASPD therapeutic understandings and further research into to training differences in terms of ASPD may be useful. Additionally, the three Counselling Psychologists Jane, Aga and Claire spoke variously from the five different therapeutic subject positions. It is of interest that Aga and Claire mainly spoke from the therapeutic subject-positions of "Resisting to Psychiatric Norms" and "Critical

Questioning” respectively, that formed resistance practices against the extant expert knowledges.

Furthermore, all participants self-identified as having had clinical experience with ASPD. All participants worked in NHS medium secure units and/or prison settings and some participants had also experience working in community services, universities, corporate environments as well as private practice. The context of medium secure units was found to be of great significance in terms of influencing the participants’ accounts who spoke from certain therapeutic subject positions. For example, the context of medium secure units seemed to be highly influential in the discursive production of “Dangerous to Know” as well as “Resisting to Psychiatric Norms” highlighting the particular power relations that were discussed in Chapter Four. Another significant contextual influence identified was related to the therapeutic subject-position of “The White Collar Psychopath” and was highlighted as appropriate in the analytic account. Lisa, Jane and Ellis who spoke strongly from this therapeutic subject-position drew from private practice and their work in corporate environments.

Finally, in terms of post-qualification experience the sample encompassed participants with one to twenty-five years of experience. However, no influence of the post-qualification years of clinical experience was noted in the analytic findings. This does not mean that there would not be no differences between newly qualified and experienced practitioners in terms of their positioning in relation to ASPD knowledges and practices, but may be the focus of this study did not allow those to emerge. Perhaps further systematic exploration may reveal some differences, if any, based on post-qualification clinical experience.

5.3.4 Researcher's Reflexivity

It is acknowledged that in this research, my influence as a researcher, a trainee Counselling Psychologist and a person was an inevitable aspect of the interpretative process. Hence, the choice of the research subject, research question, data collection, interviews and the analysis have been variously influenced by the researcher (Harper, 2003). However, from a poststructuralist perspective, the researcher's influence on the interpretive process is unavoidable and is seen to operate regardless of the methodology or method (Finlay & Gough, 2003). For example, some specific phenomena captured my interest and thus I decided to include or exclude certain information based on my knowledge of ASPD, my professional training, my previous clinical experience and what I thought would be most relevant to the Counselling Psychology as a profession.

As it was discussed in Chapter Three (see section 3.5), in the poststructuralist paradigm, reflexivity is a form of critique that attempts to challenge the available discursive norms and uncover what is enabled or constrained from one's understanding of oneself and one's subject positioning (Finlay & Gough, 2003; Butler, 2005). Thus, in contrast to traditional forms of reflexivity that mainly focus on a person's demographics and their cultural or theoretical influences, poststructuralist reflexivity acknowledges that one is not bound to a singular, rigid position, but can constantly reposition within the parameters of what is available (Butler, 2005). Hence, one's identity is multiple, mutable and ever fluctuating (O'Callaghan, 2010).

This study convinced me to scrutinise my own knowledges and examine how I positioned myself (or was positioned) as a researcher and a trainee Counselling Psychologist. During the interviews, as I listened to the participants talking about

ASPD, I could hear myself positioning within certain discourses rather than others. This became even more apparent during the analysis, where I found myself endorsing unknowingly certain ways of 'doing' ASPD becoming subjected to the discursive power relations circulating. On reflection, my own attraction to the social constructionist discourse may have impacted on the analytic comments in the therapeutic subject-position of "Critical Questioning". Although FDA suggests that any subject-position enables certain ways of thinking, feeling and relating whilst it forecloses others (Willig, 2013), my analytic commentary in "Critical Questioning" mainly focused on what is enabled rather than including what is also constrained in this particular therapeutic subject-position. For example, additionally it could have been also argued that in this therapeutic subject-position the resistance as 'rising above' could be seen as an avoidance or defence against clinical responsibility. Perhaps, the emphasis on what is enabled is 'evidence' of my own discursive limitations as a researcher and a trainee Counselling Psychologist.

Finally, overall this study not only initiated the questioning of my own assumptions about ASPD and its therapeutic applications but also contributed to developing a critical stance towards my training, my clinical practice as well as psychological therapy as a discipline in general. Contesting my own 'truth claims' and discursive positions, I seem to deploy as a researcher and a trainee, enabled me to *think* and *thinking differently*. Hence this thesis is a testament of my attempt to develop a critical 'mind', an aspect that has undoubtedly become central to my identity as a CoP and a person.

5.4 Suggestions for future research

Some suggestions for further research has been noted above (see section 5.3.3). Here I specifically propose two additional studies inspired by this research and the present findings. Firstly, widening the participant group to include various mental health professionals such as psychiatrists, psychiatric nurses, forensic psychologists, probation officers, forensic support workers as well as law enforcement officers or police staff that work with this particular ASPD group may further shed light on the opacity of the ASPD construct and the diverse discursive resources further enhancing the present findings. Exploring different perspectives on ASPD conceptualisations may further unmask complex discourses and power relations. This may lead to interrogating diverse 'truth' claims related to ASPD and encourage critical and reflexive thinking within different professional contexts.

Secondly, interviewing clients that have been labelled as ASPD may offer a unique and extremely valuable perspective for Counselling Psychology and other therapeutic disciplines. Exploring how clients understand the diagnostic label of ASPD as well as any implications this may have for their subjective experience and identity can be of great importance. Furthermore, an FDA study into clients' construction of ASPD may uncover how clients come to form themselves as well as position themselves in relation to being identified as a problem. This may further give way to uncovering how clients position themselves in therapy and any possible implications with regards to self-governance.

5.5 Final thoughts

I would like to acknowledge that this research has produced one reading of many possible. I do hope that this thesis has contributed to the creation of a critical and reflexive space for psychological practitioners to consider their knowledge and therapeutic practices with ASPD. My aim was to invite psychological practitioners to foster curiosity about their own 'truth claims' in relation to ASPD and become open to the possibility of *thinking critically* and *differently* about their therapeutic work.

Additionally, remaining faithful to the FDA analytic interest it is acknowledged that the participants' accounts have been subjected to interpretation and critique. It is important to mention that I hold a profound respect for the research participants, their knowledge and therapeutic work. This study had no intention to repudiate or desert the valuable therapeutic work these PPs conduct with ASPD clients, nor to suggest that they are naïve practitioners unaware of the complex processes that embed therapeutic practices with ASPD. The therapeutic subject-positions and their illustrative discourses merely offer alternative ways for all psychological practitioners to interrogate and critique ASPD knowledges and practices that may have been overlooked. This consideration, I believe it to be an ethical responsibility of any practitioner including myself.

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APPENDICES

APPENDIX 1: DSM-5 Diagnostic Criteria for ASPD (APA, 2013: 659)

Diagnostic Criteria	301.7 (F60.2)
<p>A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:</p> <ol style="list-style-type: none"> 1. Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest 2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure 3. Impulsivity or failure to plan ahead 4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults 5. Reckless disregard for safety of self or others 6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations 7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another <p>B. The individual is at least 18 years.</p> <p>C. There is evidence of conduct disorder with the onset before the age 15 years.</p> <p>D. The occurrence of antisocial behaviour is not exclusively during the course of schizophrenia or bipolar disorder.</p>	

APPENDIX 2: ICD-10 Diagnostic Criteria for Dissocial Personality Disorder (WHO, 1994)

Diagnostic Criteria	F60.2
<p>Dissocial (Antisocial) Personality Disorder, usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and characterised by at least 3 of the following:</p> <ol style="list-style-type: none"> a. Callous unconcern for the feelings of others; b. Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations; c. Incapacity to maintain enduring relationships, though having no difficulty in establishing them; d. Very low tolerance to frustration and a low threshold for discharge of aggression, including violence; e. Incapacity to experience guilt and to profit from experience, particularly punishment; f. Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society. 	

APPENDIX 3: RESEARCH LETTER



Maria Pournara
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Ave
London, SW15 4JD
pournarm@roehampton.ac.uk

To whom it may concern,

I am a Trainee Counselling Psychologist on the Doctoral programme at Roehampton University. I am researching Psychological Practitioner's views, knowledge and clinical experience of Antisocial Personality Disorder (ASPD). This study has been approved under the procedures of the University of Roehampton's Ethics Committee.

I am looking to recruit ten qualified and experienced psychological practitioners with self-identified experience of working with ASPD to participate in my research. I would like to interview these practitioners for 60 to 90 minutes about their knowledge of and experience of working therapeutically with ASPD.

If you are willing to advertise this research in your organisation please use the leaflet attached to post on any noticeboards or give out in team meetings. If you know of any psychological practitioners who may be willing to take part in this research please contact me or the Director of Studies at the address below. If you have any further questions please do not hesitate to contact me or the Director of Studies (see contact details at page 2).

I believe that the proposed study will add to the existing knowledge of Antisocial Personality Disorder and its clinical applications and this may be beneficial for psychological practitioners and the wider clinical field they practice in as well as people who may use the relevant services. I would be grateful if you would consider helping me recruit for this research.

Thank you in advance for your time and help.

Yours sincerely,

Maria Pournara
Trainee Counselling Psychologist
pournarm@roehampton.ac.uk

Contact Details:

Researcher Contact Details:

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Director of Studies Contact Details:

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Senior Lecturer
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Whitelands College
London SW15 4JD
Tel: 020 8392 4529
Anastasios.Gaitanidis@roehampton.ac.uk

APPENDIX 4: RESEARCH LEAFLET



Are you a qualified psychological practitioner who has clinical experience working with Antisocial Personality Disorder?

I am conducting a study on psychological practitioners' views, knowledge and clinical experience with Antisocial Personality Disorder (ASPD).

I am a Counselling Psychologist in training on a Doctorate Counselling Psychology programme at Roehampton University. I would like to interview qualified and experienced psychological practitioners (clinical/counselling psychologists, psychoanalysts, psychotherapists, counsellors) who have worked therapeutically with Antisocial Personality Disorder (ASPD). I believe that psychological practitioners' knowledge and experience of working therapeutically with ASPD is valuable and could contribute significantly in the under-researched domain of ASPD. Developing our understanding of ASPD and its clinical applications may benefit not only the clinicians and the services they practice in but also the people who are using the relevant services.

If you think you or anyone you know might be interested in participating in this research or if you would like more information then please contact me in confidence at:

Maria Pournara
Trainee Counselling Psychologist
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Ave
London, SW15 4JD
pournarm@roehampton.ac.uk
tel: 07834389401

APPENDIX 5: PARTICIPANT INFORMATION FORM



PARTICIPANT INFORMATION FORM

Title of Research Project: How do Psychological Practitioners construct and work therapeutically with Antisocial Personality Disorder (ASPD).

Thank you for considering participating in this research. Please take time to read the information below. Do not hesitate to contact me if you have any further queries.

Brief Description of Research Project:

This research study aims to investigate the participants' knowledge, views and clinical practices in relation to Antisocial Personality Disorder (ASPD) hoping to highlight a multi-level understanding of this mental health diagnostic category and its clinical applications. The participants will be qualified and experienced psychological practitioners with self-identified experience of working therapeutically with ASPD.

In this study, you will take part in an interview that will last between 60 to 90 minutes. There will be four broad areas of exploration related to your knowledge, understanding and clinical experience of ASPD.

Right to withdraw:

You can withdraw from participation in this study at any point without needing to justify your decision. In order to do this, please contact the researcher with your participant number, which you will find on the Debrief Form. Please be aware that although you may decide to withdraw your consent data in a collated form may still be used.

Confidentiality and anonymity:

All data will be held securely in password protected computer files and locked filing cabinets. No one outside of the research team will have access to your individual data, and anonymity will be protected at all times. People within the research team will be unaware of any links between your identity and the data collected. Signed consent forms will be kept separately from all other data. Your identity is not traceable and will not be passed on to anyone who is not involved in this study, and will be protected in the publication of any findings. Confidentiality will be kept at all times unless there is a real concern about your safety or others' safety.

Thank you for taking the time to read the research information and your consideration to take part in this research. Your participation in this study will be immensely valuable.

If you have any further queries please do not hesitate to contact me or my Director of Studies.

Investigator Contact Details:

Maria Pournara
Trainee Counselling Psychologist
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Tel: 020 8392 4529

APPENDIX 6: PARTICIPANT CONSENT FORM



Participant ID Number:

PARTICIPANT CONSENT FORM

Title of Research Project: How do Psychological Practitioners construct and work therapeutically with Antisocial Personality Disorder (ASPD).

Brief Description of Research Project, and What Participation Involves:

This research study aims to investigate the participants' knowledge, views and clinical practices in relation to Antisocial Personality Disorder (ASPD) hoping to highlight a multi-level understanding of this mental health diagnostic category and its clinical applications. The participants will be qualified and experienced psychological practitioners with self-identified experience of working therapeutically with ASPD.

Ten participants will take part in this study. Each participant will participate in an interview that will last between 60 to 90 minutes. There will be four broad areas of exploration related to the participants' knowledge, understanding and clinical experience of ASPD. The interviews will be audio recorded and will take place at the participants' work place or at accessible and appropriate professional space that will be arranged by the researcher. Confidentiality will be kept at all times unless there is a concern for the safety of participants or others.

Investigator Contact Details:

Maria Pournara
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD
Email: pournarm@roehampton.ac.uk

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details: Head of Department Contact Details:

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Tel: 020 8392 3627

APPENDIX 7: PARTICIPANT DEBRIEF



Participant ID Number:

PARTICIPANT DEBRIEF

Title of Research Project: How do Psychological Practitioners construct and work therapeutically with Antisocial Personality Disorder (ASPD).

Thank you very much for taking part in this study, we appreciate your valuable contribution.

This study was aiming to examine how psychological practitioners understand ASPD and work with it therapeutically. For this study, we used interviews to collect the appropriate data as this will allow to materialise the research objectives.

- I agree that the interviews have been conducted professionally and ethically.
- A copy of the transcription will be send to me within a month and a half after the interview.
- My anonymity is ensured in this project and in all future publications that may derive from this thesis.
- Confidentiality will be kept unless there is a concern for the safety of participants or others.

Participant: Researcher:.....

Signature: Signature:.....

Date: Date:

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.

Investigator Contact Details:

Maria Pournara
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Head of Psychology:

Dr Dianne Bray
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Tel: 020 8392 3627

If the interview causes emotional distress or discomfort please speak to your clinical supervisor. Alternatively, if you would like to access an independent source of support you may find useful approaching any of the following professional bodies:

BPS

www.bps.org.uk

Tel: 0116 254 9568

Email: enquiries@bps.org.uk

UKCP

www.ukcp.org.uk

Tel: **020 7014 9955**

Email: info@ukcp.org.uk

BACP

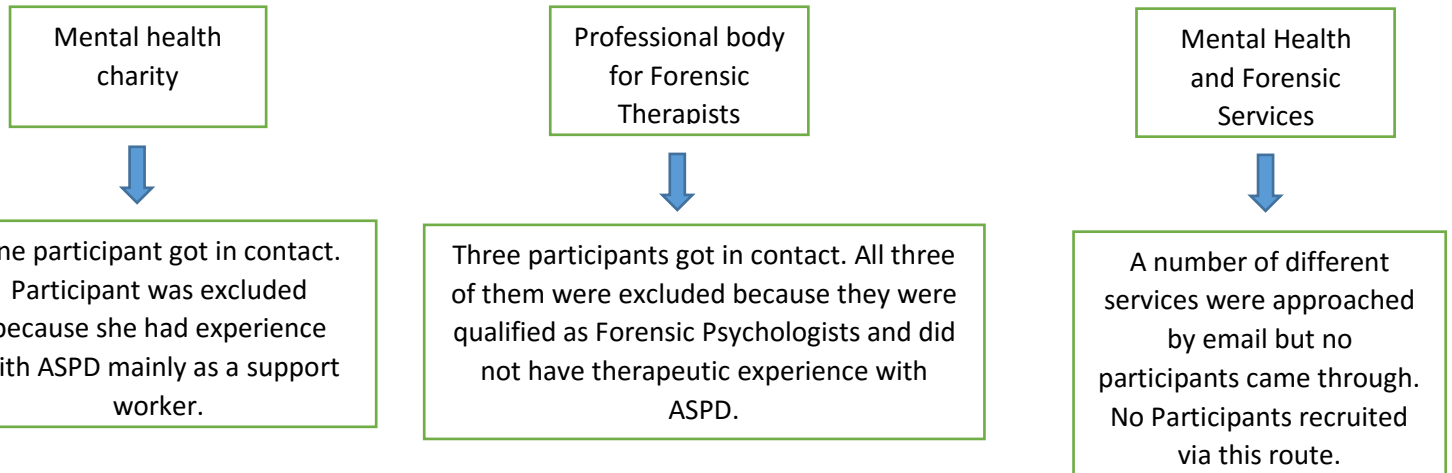
www.bacp.co.uk

Tel: 01455 883300

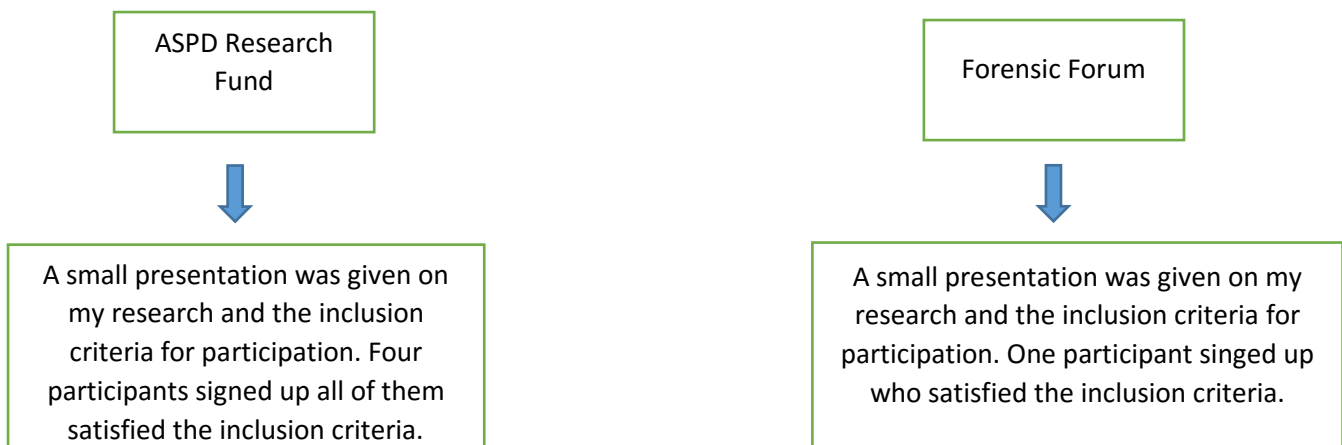
Email: bacp@bacp.co.uk

APPENDIX 8: PARTICIPANT FLOW CHART

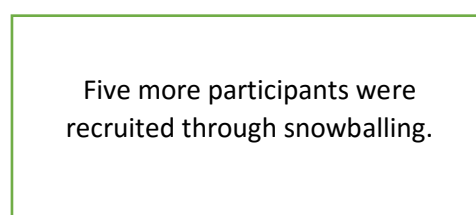
1st step:



2nd step:



3rd step:



APPENDIX 9: DEMOGRAPHICS TABLE

Gender	Ethnicity	Nationality	Qualification	Years Post-qualification	Theoretical Orientation	Work Setting
F	Black British Caribbean	British	Clinical Psychologist	5	Integrative/ Taking further Psychodynamic training	NHS/ Medium Secure Unit
M	White British	British	Senior Psychotherapist	25	Psychodynamic psychotherapist/ Group Analyst	NHS medium secure unit/ Lecturer
F	White/Eastern European	Polish	Counselling Psychologist	5	Integrative	NHS Medium Secure Unit
F	White British	British	Counselling Psychologist	20	Integrative	Prison/ Lecturer/ Private Practice
F	White British	British	Senior Psychotherapist	25	Psychodynamic	Consultant/ Private Practice
M	White British	British	Clinical Psychologist	2	Integrative	NHS Medium Secure Unit
F	White British	British	Clinical Psychologist	4	Integrative	NHS Medium Secure Unit
M	Irish	Irish	Psychotherapist	1	Psychodynamic	Prison/ Private Practice
M	White British	British	Clinical Psychologist	4	Integrative	NHS Outpatient Service
F	White British	British	Counselling Psychologist	2	Integrative	NHS Medium Secure Unit/ Community Service